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Thesis

SOCIAL ASPECTS OF CONTEMPORARY ATTEMPTS TO ORGANIZE MEDICAL CARE IN THE UNITED STATES

by

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TOPICAL OUTLINE

CHAPTER I

INTRODUCTION

I Health Problems

"The health of every individual is a social concern and responsibility."[1] As Dr. Parran said at the National Health Conference in July, 1938, "People in general are beginning to take it for granted that an equal opportunity for health is a basic American right."[2] Dr. Sands tells us that "There is no physical and mental balance without a true social life, no social balance without health."[3] He goes on to say that "social progress is antagonistic to disease, infirmity, and death; a people so fortified produces more wealth, and consequently can raise itself to still better conditions of life."[4]

These statements merely verify the feeling we all have that health is our God-given right, just as is life, liberty, and the pursuit of happiness.

This belief that health is of vital importance in an efficient, satisfactory, productive, and happy existence; that health is a prerequisite to fruitful living; that health does not maintain itself unaided; that many people do not receive adequate medical care; partly because of its high cost, and

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1. Rorty, James H. American Medicine Mobilizes. New York: W.W. Norton and Company, 1939, p.228.

2. Ibid. p.25.

3. Sand, Rene. Health and Human Progress. New York: MacMillan Company, 1936, p.8.

4. Ibid. p.14.

partly because it is not available is the reason for discussing in this paper some of the contemporary attempts to improve the organization of medical care in the United States and the social aspects of such attempts.

Material gathered from books by both medical and non-professional men, reprints, reports, pamphlets, articles from various magazines, clippings from newspapers, and interviews with professional and non-professional people have furnished the background. This is not an attempt to write all that might be said, or to cover in detail all phases of medical care. It is an honest effort to show why good medical care should be available to all-from rich to poor; to show ways in which such care may be provided, and the effect on individuals, and on society.

Good health is desirable for both the individual and society:

The individual who is not well integrated physically, mentally, socially, and emotionally, is always working under a handicap. He is more susceptible to illness and to chronic disease. He is inclined to lose working days, thus lowering his income. This, in turn, tends to lower his standard of living, as well as tending toward social, emotional, and eventually, moral mal-adjustment. Productivity and happiness go with good, not poor, health.

Good health is essential to society for much the same reason. Society is based on man. If we are to have a well-balanced, productive, efficient and moral society, we

must have healthy people forming that society. In times of depression, the health of society as a whole decreases, moral standards tend to become lower, living standards tend to drop, and society tends to retrogress rather than to progress.

Dr. Parran has said: "In good times and in bad times, sickness is a major cause of poverty, destitution, and a large part of all dependency. Through periods of prosperity and of depression, sickness still remains the most constant factor in dependency. It occurs more frequently,for longer periods among the unemployed than among the employed, among the poor than among the rich. It is associated with various other manifestations of social disorganization, such as: unemployment, low income, poor housing, and inadequate food. If we are to lessen destitution and poverty, if we are to penetrate to the causes of dependency, we must strike simultaneously at this whole plexus of social evils within our society. It is of little avail to employ modern techniques in solving the problems of unemployment, housing, and low wages, if we leave to the forces of laissez-faire the problem of sickness which pervades and contributes to these other factors in dependency, because so frequently it strikes down the otherwise self-supporting person."[5]

Dr. Parran goes on to add: "Many widows and orphans are now being supported at public expense, who have been deprived of their natural supports by preventable accidents and equally preventable diseases. Many persons are now among the

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5. Rorty, James. American Medicine Mobilizes. New York: W.W. Norton & Company, 1939, p.49.

unfortunate whom we label as the 'unemployables' solely because they could not afford the medical care that would have kept them employable and independent. So long as we fail to provide adequate programs for medical care and for protection against loss of earnings, just so long are we permitting the creation of a permanent class of disability-dependents."[6]

In war times, especially, good health is important to society in keeping up the productivity of materials, morale, and, in the last analysis, the saving of human life. We are told that 'a reduction of 10 per cent in the four hundred million man-days lost annually from illness and injury in industry represents the time required to build five capital ships, sixteen thousand tanks, or nine thousand bombers.' According to an estimate made by the Gallup Poll, the time lost from war industries or war-connected industries, because of illness in a single month could have built two heavy cruisers, 448 medium bombers, or 3,200 light tanks."[7] If this is true, there can arise no question as to the vital importance of the health of the worker in the winning of this world war.

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6. Ibid. p.50

7. "The Health and Safety of the Worker", Health Bulletin for Teachers. Metropolitan Life Insurance Company, Vol.XIII,No.8, p.29.

II Three Aspects of Health

This problem of health presents three definite aspects: (1) positive health; (2) prevention of disease; (3) treatment of disease;- or, as we might phrase it- positive, preventive, and curative health.

(1) Positive health may be defined as " a state in which the body is ready to act in all its functions duly and freely and comfortably in response to reasonable demands, and having acted is able to restore itself promptly to its resting state and to renew itself for further action."[8] Positive health depends on biological inheritance and environmental factors. Individuals possess varying physical, mental, and emotional capacities. Environmental conditions develop or impair the use of these capacities. What may prove good for one individual may not prove advantageous to another, but, in general, certain conditions pertain to everyone. Good environment includes: an occupation carried on under healthful working conditions; an adequate income; sanitary housing arrangements; proper nutrition; adequate facilities and opportunities for play, recreational activities and social contacts; and adequate medical care. Education which provides knowledge of and an intelligent attitude toward the use of the opportunities and facilities available, and toward a planned program of healthful living is a vital part of good environment.

Positive health also includes proper mating and bringing into the world children adequately endowed physically, mentally, and emotionally to meet the demands of this world. It goes further, to

8. Meredith, Florence L., M.D. The Science of Health-Philadelphia: The Blakiston Company, 1942, p.9.

the planning of bringing children into the world according to the ability of the parents to provide adequate environmental conditions so that each individual is able to make the most of his unique capacities; and so that society will not be burdened further with unemployment, disease, dependency, degeneracy, and crime.

Positive health is a phase of health too often neglected by the majority of people who believe in live and let live; or one has a good or a poor constitution and there is nothing one can do about it; or health belongs to the rich and sickness to the poor.

Positive health involves not only a good physical,mental and emotional constitution, but an adequate environment which provides employment and a living wage, facilities for carrying out a well-balanced program of living, facilities for adequate and not too costly medical care, and knowledge and intelligent attitudes toward health and the opportunities and facilities for maintaining health.

(2) Preventive Health, or prevention of disease, has become largely a Public Health function. The increased knowledge of the causes of disease and of the use of vaccines, serum, and various other means of preventing disease, and the fact that communicable and chronic diseases affect people as a whole, and not individuals alone, has brought this side of medical care into the wide field of public attention.

Preventive health includes: sanitation, good housing conditions, water purification, pasteurization of milk, inspection of food, vaccination against communicable disease, prevention and care of tuberculosis, cancer, rheumatism, mental illness, and venereal disease.

Preventive health or prevention of disease, is a vital factor in maintaining and conserving good health as well as in preventing sickness. Prevention of disease involves education of the public to the importance of prevention and to the use of the means available for such protection.

(3) Treatment of disease, or the curative side of the health problem, has often been the only side considered. Although for the past fifteen or twenty years, the medical profession has been trained to take special interest in preventive care, many people have failed to realize this fact. For one reason or another, individuals have waited until a full blown illness has developed before seeking medical aid. Thus, in many cases, hospitalization and nursing care as well as medical care have been necessary, when earlier recourse to a physician might have involved only the physician's bill.

The resources of the individual, the availability or the non-availability of medical care, and the unintelligent attitude of many individuals toward the medical profession have had much to do with the tendency toward the use of old-time cures and drugstore remedies. Nor must we forget the attitude that nature cures if left alone to do the job.

On the whole, treatment of disease has been the one side of the health picture which has received the most general and adequate attention down through the years. Often the care may have come too late, and have been too little to prevent chronic illness, incapacity, and even death, but when one is vitally stricken, somehow, and from somewhere, medical care is obtainable.

III Financing the Programs for Health

Financing the programs for health is one of the major considerations in the problem of increasing the efficiency, productivity, and happiness of society.

(1) Positive health is as yet a not clearly envisaged program. We seem not to know just where the responsibility lies,--is it private or is it public ? Employment, a living wage, sanitary housing conditions with planned play areas for children and adults seem to place themselves in the public field. It is said to be the responsibility of not only the community but of the government to see that these necessities of living are provided and made available to all.

We may not stop there, for positive health demands education as to what is positive health. Here the school, the medical profession, the State and the Federal governments must be responsible for education. Free education is the right of all citizens in a democracy. This right should include education in the field of health.

Education alone will not do the job. The realization of the importance of positive health, of its contribution to full living, must be brought home to the public and to the individual, and a desire for positive health created within the individual.

Adequate sleep, work, recreation, exercise, nutrition, and social experiences which form a well-balanced program of living, are the responsibility of the individual, once society has provided the first essentials of knowledge and of facilities.

Thus, it seems to me, that the financing of this program devolves on both the public and the individual, while appreciation and use of such a program are up to the individual.

(2) Prevention of disease has been envisaged as a public responsibility, but has not been adequately carried on. Much has been done, and concerted efforts have been made to control infant mortality, maternal mortality, tuberculosis, cancer, mental illness, and the acute communicable diseases. Laws covering sanitation, purification of water, pasteurization of milk, housing, food, and drugs have all helped in this program. The distribution of funds, the needs of the rural versus the urban areas still leave this a vast program to be solved.

The matter of physical examinations, dental prophylaxis, the detection of disease before it actually occurs, are still primarily the responsibility of the individual. Moreover, use of the preventive means offered by Public Health departments rests, to a certain extent, with the individual.

Financing of the treatment program has been the area of greatest controversy. Charity care has been provided by private clinics, private, non-profit, and state hospital clinics, and out-patient departments. This care has been extended to others at little or no cost. This does not take care of the large majority of the population for whom traditionally this care has been on an individual basis, and who have expected and have been expected to provide it for themselves.

The patient has sought his own doctor, usually with the

expectation of paying, when and if he could, whatever the physician saw fit to charge. This personal relationship has been a supposedly vital link in caring for and in curing the patient. Free choice on the part of the patient, faith in his choice, and the fact that he was paying (or supposedly paying) for what he received, seemed the essence of good treatment.

The facts that inability to pay and the wish not to incur charity, lack of ready access to a physician as in rural areas, lack of knowledge on which to make a choice, and lack of knowledge of how much the treatment might cost were and are all features of this financing which have often made treatment too inadequate and too late,-also much more expensive than if preventive care had been indulged in.

There is also the physician's side of this picture. He has been trained to treat, to cure. He must make a living, and since 20% of his bills are uncollected, and since he gives a certain portion of his time to charity, he must try tc cover his overhead, his unused time, and his educational expense through the fees which he does collect. Again, he must try to determine the ability of the patient to pay, and try to keep his charges within possibilities of collection. He must estimate his work and his patient's evaluation of his work. This sliding scale of charges tends to result either in too much charity or too little care on the one hand; or prolonged, unnecessary care to that patient who can afford to pay his bills. I do not mean to insinuate that the average physician tries to charge too much or to prolong unnecessary treatment, but the physician must live, and until he is well established,

he must either take on too many paying fields so that he does justice neither to himself or to his patients; must pamper some people into prolonging their illness; "soak the rich" and split fees; or live on a low margin himself.

Hospital care and nursing have also been a matter of individual payment. Here again, too often the general physician and even the surgeon have suffered because of hospital bills which had to be met. In many cases, care desired and not a necessity, on the part of the patient, ate up the financial resources of the patient before the physician received his allotment.

(3) Breaking Down of Private System of Payment.

This individual or private system of payment for treatment has gradually been breaking down. The reasons are varied. Primary among them is the increased cost of what is now considered adequate medical care. Science has advanced so far, has recognized so many diseases formerly unknown, has developed so many new treatments, and new methods of diagnosis that specialization, consultation, X-ray, and laboratory techniques are now considered essential parts of good care. This advance of medical science carries with it the need for more specialized knowledge, extensive equipment, access to hospital facilities and to specialists in given fields of medicine,

The increased cost of such care has caused the patient to hesitate because he can no longer have any idea of what expenses may lie ahead of him. The average man dreads to mortgage an already over-allocated and,in many cases, over-mortgaged budget.

These advances in medical care have tended to increase the uneven distribution of physicians to population. Specialization, needs for special equipment and laboratory techniques tend to keep the doctors close to a large center where access to facilities and hospitals is available. Where, too, the opportunity for keeping posted on new developments is equally possible. This results in the poor and rural areas having less and poorer medical care available, and in the incomes of the physicians in those areas being lower than for those in the urban districts.

The change of population from a largely rural to a largely urban one is another important factor. The trend to large scale farming, the advance of industrialism, the free mode of transportation have all brought a change in distribution of population, so that reduced and widely scattered rural areas hold no appeal and no financial hope for the medical profession. Facilities for maintaining up-to-date medical care are too expensive and too inaccessible; the number of patients is too scattered and too few for a physician to make even a bare living. Moreover, with automobile transportation, many rural people tend to drive to the city, with its greater facilities and its specialists, for all but emergency medical care. This tendency toward urbanization of population carries with it a change from the old plan of family doctor for various reasons. In cities, especially in the larger ones, the tendency is to do without a family doctor, partly because such physicians seem to have gone out of style; specialists seem to predominate. People know little about their neighbors and thus do not know how to choose a family physician. It is the style to do without, to "keep up with the 'Joneses'- out-do them if you

can-, and there is no money left over for health care. Lastly, taking care of one's health is looked upon as a fad in which only the wealthy may indulge.

The increased cost of medical care and the tendency toward staying near a large hospital center has disadvantages as well as advantages for the general physician. The costs of his profession are greater. The number of specialists and of physicians in relation to population is greater, Competition for these people as patients tends to become more intense, and obtaining the average income of the physician becomes more of a struggle. Thus, his feeling of financial and social security becomes less.

The demands on the pocketbooks of the middle class, in order to maintain fair living standards(as we conceive them)-have increased so heavily that little remains for the budgeting of medical care. Disease and sickness are unpredictable, and if sickness does fall unluckily upon you, you will probably be unable to meet it by means of any ordinary savings for that purpose. This, and the increased realization of the importance of medical care, in efficient living, have brought the community to a realization that medical care is the right of every individual, just as is education. The increased interest of the community in preventing epidemics, in reducing contagious disease, in treating chronic disease, in caring for tuberculosis, venereal disease, and mental affliction, are all telling points in the breaking down of this individual financing of the treatment of disease.

People have begun to appreciate that the "economic loss

due to sickness is a very serious matter, not only for many families with and without incomes, but for the nation as a whole."[9] The elimination of this sickness must be met. There are still many people who have no desire for charity and who refuse to accept it. These same people desire medical care at a cost which they may have some hope of being able to meet.

Provision for medical care made by industrial concerns has been another contributory factor. Group medical practice thus arranged, has started people to thinking. While these provisions vary in different organizations, people have begun to believe that medical care can be provided more cheaply through group than through private practice. They are looking for ways and means as individuals to avail themselves of such opportunities.

The increase in the co-operative movement in the United States has created interest in the possibilities of medicine on a co-operative plan, and has been another rung in the ladder toward change.

Group medical care plans inaugurated by special groups of physicians and of societies have added further fuel to this fire.

Needless to say, there are still many people who believe that this individual method of financing treatment of disease and medical care in general is by far the best, the most dignified, the fairest, and the most righteous method. The fact that the vast majority of people have seemed to be unable to provide for adequate medical care under this plan, has brought more forceably to the individual, the nation and the medical profession the question of how best to provide the medical service which is needed.

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9. Rorty, James H. American Medicine Mobilizes. New York: W.W. Norton and Company, 1939. p.25.

CHAPTER II

MEDICAL CARE: ITS COST AND PAYMENT.

Part I Medical Care and its Cost:

What is good or adequate medical care ?

Before we can discuss its cost and payment intelligently, we must know to what we are referring. Doctor Reed has said:

"Every kind of service which may be necessary for the prevention and cure of disease, and for the promotion of full mental and physical efficiency should be at the disposal of every member of the community."[1]

"Adequate medical care is dependent upon the needs of the particular case. In some instances, it means the provision of bread and milk; in others, it means the use of the newest and most refined mechanism of diagnosis....it is futile...to define, adequate medical care more specifically than by saying that it consists of whatever the trained judgment of a recognized diagnostician and physician perceives to be necessary for returning the individual to health and to competence."[2]

Thus we see that adequate medical care ranges from good common sense and the provision of adequate nutrition to the most detailed techniques of medical and hospital care. This care will include not only diagnosis including laboratory tests, X-rays,

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1. Reed, Louis S. Health Insurance. New York: Harper & Brothers, 1937, p.3.

2. American Medicine. "Expert Testimony Out of Court". New York: The American Foundation, Inc. 1937, Vol. I, p.2.

consultation of specialists, hospital and nursing care as needed but will include maternity care, dental care, rectifying of eye difficulties, immunization, as well as periodic physical examinations, and the provision of drugs. Adequate medical care must be preventive as well as curative. It is far less costly both to society and to the individual to prevent sickness, with its accompanying unemployment, its loss of working power, and income, its tendency to chronic disease and dependency, and to a high rate of mortality, than to cure sickness.

(2) The Cost of Medical Care.

The cost of medical care depends on the extent and quality of the care. Since the amount of such care needed is unpredictable for any one person or family, one cannot say what may prove to be the cost in any one year for any one person.

The unpredictability of cost makes it difficult for any but the well-to-do to save adequately for excess expenses which may arise. This means that either a large share of savings previously accumulated must be eaten into, incase of unexpected, lengthy, or serious illness; or that the individual must borrow money with which to pay. Thus another obligation is incurred, and, if one is conscientious, it means doing without other necessities of life; the alternative is that the physician, the hospital, and society as a whole, must shoulder the unpaid debts.

"Rather general is the feeling that the low income group, whether through installment buying or other crowded commitments for things they need and want, are signed up for so much that there is no room left. If and when illness comes,

they lapse into helplessness. If it were a matter of not being able to meet the current payment on the radio which they chose and bought, they would try to do something, but illness they did not order. Moreover, the cost of it is so far out of relation to their budget that whatever they could scrape up amounts to only a drop in the bucket. Commonly, they cease trying to stretch their resources to meet the impossible, and subside into helplessness."[3]

The question arises here as to whether medical care should not receive a larger budget allotment to start with. What of the relative importance of health compared with radios, automobiles, and similar budgetary items ?

(3) Sickness and Need for Medical Care:

The report of the Committee on The Costs of Medical Care, based on a nation-wide survey of illness and costs of medical care among 9,000 white families, showed "there was substantially the same incidence of illness per family or per individual in the various broad income groups. Families with incomes under $1,200 or $2,000, however, receive far less medical service than those with incomes of $5,000 or of $10,000 or over. ...It is evident that the two or three lowest income groups receive far less of nearly every service- care from physicians and dentists, hospitalization, eye care, health examinations, immunization, special nursing, maternity care, and X-ray and laboratory service-than groups with the highest incomes. The group with the

3. Ibid. p.86

lowest amount of service (which was not in every case the group with the lowest amount of income) received only 50% as many days of hospitalization, and 41% as many calls from physicians as the group with the highest amount of service. In every instance, the latter is the group with the highest income. Only one-fifth as many persons in the lowest group receive any dental attention. The families with incomes of $1,200 to $2,000 receive even less hospitalization and preventive services than do the families with incomes under $1,200."[4]

The National Health Survey made of 740,000 families in urban communities in 19 states and of 36,000 families in selected rural areas in 3 states, between October 1, 1935, and March 30, 1936, estimated that, "six million persons in the United States are unable to work, attend school, or carry on other usual activities each day during the winter months on account of illness, injury, or impairment resulting from disease or accident. The proportion of those sick on an average winter day was found to vary widely with age. Old persons, sixty-five years of age and over, had the highest proportion of sickness, about one in every eight. Youth was found to be the healthiest age group, the proportion of those sick between the ages of 15 and 24, being only one in forty. In childhood, the proportion was higher, being... a little more than one in twenty-two."[5]

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4. Committee on Costs of Medical Care- Medical Care for American People. Final Report. Chicago University-University of Chicago Press, 1932 No.23, p.11.
5. Amidon, Beulah. Who Can Afford Health ? New York: Public Affairs Committee, No.27, 1939, p.8.

Thus, "during the year there are approximately 22,000,000 disabling illnesses for the country as a whole, lasting a week or longer, each lasting, on the average, about 57 days."[6] This, in terms of the "average" citizen, represents 10 days of incapacity from an illness or injury which lasts one week or longer during a 12-month period. Somewhat under one week in a year is lost by the child under 15 years of age, while people between the ages of 15 and 16 years, lose approximately 9 days a year. Children are ill more frequently than adults, but their illnesses do not last so long. The average old person (over 65) is disabled almost five weeks annually, as the result of frequent and prolonged illness. Thus, "the total loss to the nation from illnesses disabling for one week or longer is close to one and a quarter billion days each year lost from work at home, as wage earner or from school."[6a]

The most frequent cause for illness in winter was, as one would expect, respiratory diseases, including colds, influenza, grippe, pneumonia, and tonsilitis. The second group was that of chronic diseases such as : rheumatism, heart disease, nephritis, cancer, diabetes, asthma, tuberculosis, and nervous diseases. Permanent impairment as a result of previous disease or accident rated high in cases of illness. Injuries and accidents together with acute infectious diseases of childhood made up the remaining causes of illness.

The survey canvassed 2,300,000 city dwellers, of whom about 40 per cent were members of families with incomes under $1,000; 65% of families with incomes under $1,500, and 80 per

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6. Amidon, Beulah, Who Can Afford Health ? New York: Public Affairs Committee, No.27, 1939, p.9.

6a. Ibid.

cent with incomes under $2,000. To express it differently, "out of every five persons, two were in families of the lowest income group; two were in the $1000 to $2,000 group; while one in five was in the group with an annual income which was over $2,000. In addition, of the lowest income group, almost one-half had received relief in some form during the year 1935."

The National Health Survey confirmed the conditions found true by the Committee on the Costs of Medical Care and revealed that "fifty-seven per cent more illnesses disabling for one week or longer occur among families on relief than among families with annual incomes of $3,000 or over. The relief groups had proportionately 47 per cent more acute illnesses than the highest income class and 87 per cent more chronic illnesses."[7] Again, as one would expect, "persons in families just above the relief level (self-sustaining, but with incomes under $1,000) were sick less often than families on relief, but 17 per cent more frequently than those in families of the highest income class. Most of the difference was due to more frequent chronic sickness, for which the rate was 42 per cent higher than for families with incomes in excess of $3,000."[8]

The survey also showed that "one per cent of workers aged 15 -64 years were reported to be unemployable by reason of disability."[9] It is needless to add that the lower the income group, the greater is the proportion of unemployability.

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7. Amidon, Beulah, Who Can Afford Health ? New York: Public Affairs Committee, No.27, 1939, p.11.

8. Ibid. p.11.

9. Britten, Rollo H.,Collins, Selwyn D.,Fitzgerald, James S. Some General Findings As To Disease, Accidents, and Impairments in Urban Areas. Reprint No.2,143. Public Health Reports Vol.55, No.1, March 15, 1940, p.21.

The magazine, Medical Care, for April, 1942, tells us that the average worker loses nine days a year because of illness, eight days for men, and twelve for women. This means a loss of 350,000,000 days annually for all workers in the United States. This is equal to over a million men toiling continuously throughout a full working year. Moreover, less than one-tenth of this loss is caused by industrial accidents and occupational disease. Over nine-tenths is due to general sickness and to accidents not connected with the occupation.

Here again, we note a relationship between illness and income. Members of relief families(living on less than $1,000 per year) report a higher rate from accidents. We are told that fifty-nine per cent of accident injuries in the home result from falls. In the low income group, may this not be due to various factors such as mal-nutrition and disrepair of houses ? Inadequate lighting, poor stairways, and furniture in poor repair are other contributory causes.

We might go on indefinitely quoting figures showing illness and the need for adequate medical care. The fact is, that people in the low income group have an undue share of illness, including chronic sickness, accidents, and acute illnesses. To the low-income families this combination of illness causing loss of wages (in addition to emergency expenses, if any medical care is had) means a further reduction in standards of living. It is all a vicious circle- low income, illness, lack of adequate medical care, loss of income, and an even lower standard of living, poverty, crime, dependency, and indigency.

Let us now consider some of the expenditures for medical care and special services rendered.

Part II Expenditures for Medical Care.

(1) Individual and Family.

Two-thirds of the population have an income which puts them between the numerous poor and the few well-to-do. This group spends an average of 4 per cent of its income each year for medical care.

"Forty million of our people live on annual family incomes of $800 or less."[10] This income permits only an emergency standard of living and makes it impossible for them to purchase medical care. On the other hand, charity alone should not have to carry this group.

Another one-third of our population has a family income which does not exceed $1,500 a year.

"Families in small cities in the North Central States, with incomes from $1,200 to $1,750 are paying from $63 to $65 a year for all forms of medical care. If dentistry, medicines, nursing and appliances are excluded, and only the physicians and hospitals are considered, their expenditure for these will average about $34 annually."[11]

Dr. Rankin, of the Duke Endowment, estimated " the annual cost of medical service in the United States at $2,560,000,000. This figure, which is exclusive of public health works, amounts to $20.83 per capita or approximately $100.00 per family."[12]

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10. Sigerist, Henry E. A Health Program for the American People. New York: People's National Health Committee-Reprint, Vol.163, No.6, p.1
11. "What Will People Pay for Medical Care ?" Medical Care, Vol.2, No.11, January, 1942. Baltimore: Williams & Wilkins. p.49.
12. See page 23.

"The average wage earner's family pays $60.39 a year for medical service, the average farmer's family pays $61.60, while the average family in the clerical forces pays $80.00."[13]

Dr. Davis gives the following information:"The eighty million people whose incomes in 1935-1936 lay between $545 and $1,925 were then spending about one thousand sixty million dollars for medical care out of their personal earnings, irrespective of any costs which fell on them indirectly in incidence of the five hundred twenty million dollars of taxes."[14]

Expenditure for medical care by different income groups has been estimated as follows: the group with income under $635 spends 4.5 per cent of total income; the middle one-half of the population with an income of from $635 to $1,715 spends 4 per cent; while the top one-quarter of the population with incomes over $1,715 spends 3.5 per cent of their income.

On an average budget, medical care holds sixth place, with annual expenditures ranging about as follows: food-28.5 per cent of annual expenditure; housing 16 per cent; operation 8.9 per cent; clothing 8.9 per cent; automobile 6.4 per cent; medical care 3.7 per cent. When the family income is below $500, 7 per cent goes for medical care. If the income is $20,000 and over, the medical care expenditure is only 2 per cent. Once again, we see that the lower the income, the greater the proportionate

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12. American Foundation- "American Medical Expert Testimony Out of Court" New York: American Foundation,Inc. 1937 Vol.1 p.41.

13. Ibid. p.41.

14. Davis, Michael M. America Organizes Medicine. New York: Harper Brothers, 1940, p.209.

expenditure for medical care.

In 1935-1936, thirty cents of community funds were spent for every dollar spent from personal funds. In addition, the estimated value of free services contributed by physicians to individual patients ranged "from less than ten million dollars to three hundred million dollars or more."[15]

The total expenditure in the United States in the year 1929 was about $3,700,000,000. This covered all sorts of health and sickness services. "Of this expenditure, philanthropy and industry paid 7 per cent; government, 14 per cent; patients, 79 per cent. In 1936, the total expenditure had been cut to $3,200,000,000, of which patients paid 80 per cent; government, 16 per cent; industry and philanthropy, 4 per cent. In 1937, and 1938, government expenditures were further increased, offsetting reductions in expenditures by philanthropy and industry, but private and industrial expenditures still remain approximately 80 per cent of the total."[16]

Dr. Warbasse in his Doctor and the Public reckons that the non-governmental expenditure for health purposes in the United States is a little over three billion dollars yearly, and the government expenditure ranges around five hundred million dollars. More than twice this amount is spent by the public on automobiles. The same amount is spent by the people as individuals for tobacco and confectionery as is spent by them for medical purposes. The

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15. Davis, Michael M. America Organizes Medicine. New York: Harper Brothers, 1940, p.46.

16. Amidon, Beulah. Who Can Afford Health ? New York: Public Affairs Pamphlet, No.27, 1939, p.25.

people spent twice as much for toilet articles and cosmetics to give the appearance of health as the government spent for health purposes. Thus we see that health service expenditures receive a poor share of the national expenditure and of the people's individual budgetary interest.

"Of the estimated five hundred twenty million dollars now spent annually from tax funds for public medical services, some three hundred seventy million dollars or 71 per cent is for hospital care. About forty million dollars of the three hundred seventy million dollars represent tax funds paid to non-governmental hospitals for the care of needy persons, while the remainder, approximately three hundred thirty million dollars go to support hospitals owned and controlled by local, state, or federal governments." 17

(2) Hospitals

The auspices under which hospitals are operated fall into three broad classifications: (1) governmental- federal, state, county, or city; (2) voluntary non-profit associations and corporations; (3) proprietary, voluntary hospitals owned by individual physicians or partnerships, or by special corporations or business enterprises.

"Government hospitals provide seventy per cent of all hospital beds in the United States; but these beds---- are concentrated both functionally and geographically. Three large groups of these hospitals are concentrated functionally; mental, tuberculosis and federal hospitals."18

The care of the mentally ill and of tuberculosis is predominantly a public service. "Federal hospitals serve special groups such as: veterans, the Army and Navy personnel, Indians, seamen, the inmates and some of the employees of federal institutions. The general hospitals maintained by states, cities, or counties, constitute only about 25 per cent of all general hospital beds."18a

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17. Davis, Michael M. America Organizes Medicine. New York: Harper and Brothers, 1940, p.85.

18. Ibid. p.86.

18a. Ibid.

"Hospital care for tuberculosis alone represents an annual expenditure of over seventy million dollars."[19] More than 200,000 persons are treated in hospitals and sanitoria annually, of whom at least 85 per cent receive free treatment, and only 6 per cent pay in full, while the rest pay only in part. Tuberculosis care is no longer a matter of individual expense. It has been taken into the hands of the public because this "White Plague" is so prevalent among people so little able to care for it; and its effects uncared for are such a menace to the whole world.

Consider another angle of hospital care. City people have more hospital care than do rural people because of greater accessibility. In the cities " about 27 per cent of all disabling cases of illness had the benefit of hospital care. Wealth or poverty made relatively little difference though it did make some. For relief families the proportion was 27 per cent; for non-relief families with incomes under $1,000 , 24 per cent; for families with incomes of $3,000 or over, 30 per cent. A relatively large proportion of hospital care received by relief and low-income families was in large cities having a population of 100,000 and over. In these centers, the relief families received relatively as much hospital care as the $3,000-and-over group. In cities with a population between 25,000 and 100,000 ,only 20 per cent in the relief group received hospital care as against 29 per cent for the highest income group. In smaller towns, with

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19. Kurtz, Russell H. Social Work Year Book 1941. New York: Russell Sage Foundation, p.564.

fewer than 25,000, hospital care for persons on relief fell to 15 per cent; though the proportion of cases in the highest income group receiving hospital care remained at 29 per cent."[20]

Rural districts do not have even these opportunities for hospital care. Rural hospitals are few, smaller, with fewer facilities, and are at greater distances from the population needing such care than are city hospitals. Often a small hospital has to serve a vast rural area, and access to facilities of a large hospital may be obtained only by miles of travel involving great expense as well as great inconvenience.

Before we leave this question of hospital care, let us take a glimpse at the fact that privately owned non-profit hospitals themselves are dispensers of charity as well as of care for which money is received- sometimes in full, sometimes in part. The hospital provides not only medical, surgical, nursing, laboratory care and drugs, but has a large overhead for buildings, expensive equipment and general administrative needs. The private and municipal hospital cannot carry these financial needs on income received from patients alone. It is dependent on the charity service of its medical staff and on philanthropy. This last item has been diminishing rapidly, "Private and municipal hospitals are both kept above water simply and solely by the contributions of their medical staffs."[21]

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20. Amidon, Beulah. Who Can Afford Health ? New York:Public Affairs Pamphlets, No.27, 1939, p.18.

21. Reed, Louis S. Health Insurance. New York: Harper & Brothers 1937, p.32.

Payment of the costs of adequate hospital care is fast becoming a problem for the non-governmental hospital and, in turn, for society. Dr. Miles Atkinson says "this condition of hospital finances is one of the strongest arguments for state medical services."

(3) Dental Care.

Dental care is another item of medical care which is sadly lacking for all classes of people. Good dental care today is obtained by only the upper ten or twenty per cent of the population who can afford its price. It is not obtained by the vast bulk of the country's people. Dentists testify that in less prosperous times, one-half of the population rarely receives dental services except for relief of pain, and that extractions generally constitute the extent of such service." Figures from the United States Public Health Service indicated that :

a) 22 per cent of the people go to a dentist for all or part of the necessary service.

b) 58 per cent of the people can afford all or some dental service, but do not seek any dental service.

c) 20 per cent of the people cannot afford dental service and may be considered as the dentally indigent for whom service must be provided by others."[22]

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22. National Dental Hygiene Association. A National Program for the Advancement of Dental Hygiene. Washington,D.C. p.9.

Only about one person in four receives dental care during the course of a year, which means that among families of comfortable incomes, the majority of the persons receive dental care every year; whereas people in the lower income groups obtain dental care only occasionally, usually for relief of pain. This fact is confirmed even more fully when one finds that "the dentist draws 40 per cent of his income from the top 10 per cent of the population."[23]

The distribution of dentists is another factor in this problem. As one would expect, the percentage of dentists varies widely in different areas. There are about 65,000 dentists in the United States. This means for the country as a whole, the average number of people for each dentist is 2,100. In actuality, it ranges from an average of 1,555 and 1,910 in states like New York and Pennsylvania to one dentist for 3,800 persons in rural states like Tennessee.

Last but not least in convincing us that dental health has been very largely neglected by our population is the fact that "almost 20 per cent of all the men rejected for military service in this war were turned down because of dental defects."[24]

Once again, we have the picture of a lack in meeting health care. In this case, we find again the factor of expense, the purchasing of goods rather than of health care; the waiting

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23. Davis, Michael M. America Organizes Medicine. New York: Harper & Brothers, 1940, p.57.

24. Watts, R.M. "Dental Needs in the United States"-Medical Care, Autumn, 1941. Volume 1, No.4, p.333.

for pain and cure rather than prevention and care. Nutrition, of course, is a vital factor in dental health. Low income may be the cause, or yet again, dislike of certain foods and sheer laziness in regard to habits of eating may be the reasons for poor condition of teeth. Inaccessibility to dentists is a large factor in rural sections, and lack of free clinics in urban districts. It all sums up to lack of interest and education on the part of the people.

(4) Physicians.

What about the physicians' place in this cost and availability of medical care ? In 1941, figures showed that there were about 155,000 physicians in private practice in the United States.

"The proportion of physicians in practice to the population is about one to every 930 persons in the United States as a whole, but varies from about one for each 500 people in New York State, to about one for each 1,400 persons in Alabama."[25]

Furthermore, in large urban centers, the proportion is nearer one to every 525 persons, while the town with less than 5,000 persons averages one physician to every 1,350 persons. This disparity of number of physicians in cities and towns is still further accentuated in outlying rural areas. As we would expect,this unevenness of distribution is closely connected with the economic well-being of the population.

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25. Kurtz, Russell H. Social Work Year Book-1941. New York: Russell Sage Foundation, p.326.

Figures from the American Medical Association Directory for 1940 show that about 80 per cent of all physicians were in private practice, but of these a considerable portion derived some of their income from part-time salaries or from contracts for part-time work with public and business organizations. Full time salaried positions in hospitals, clinics, public health agencies, industries, and the like accounted for about twelve per cent. About six per cent were internes, residents or fellows in hospitals, and the remainder were retired or inactive. A large proportion of physicians rate themselves as complete or partial specialists. The tendencies toward specialization and toward full or part-time salaries and contract work have increased greatly during the last twenty years.

Incomes of physicians show wide variation; 1929 figures as shown by the Committee on Costs of Medical Care state that, for every physician receiving $10,000 net income, there were 2 who received less than $2,500. Furthermore, the contrast between specialists and general practitioners was especially marked,- with the average net income for the specialist being about $10,000 against $4,000 for the general practitioner. Again there was a wide range in average income for the general practitioner according to locality, distribution, and part-time salaried work. Many were well under the $4,000 average.

We fail to realize that, of the average bill which the patient pays, only 26 per cent or less goes into the pocket of the physician, while the other 74 per cent goes to pay the hospital, laboratory, dentist, nurse, and for drugs and therapeutic equipment.

The disproportion of physicians in urban and rural areas is partly a result of changing population distribution, the economic conditions of rural areas, the hard struggle and the long distances needed to be covered to eke out a living. These, together with the unpaid and uncollectible bills, the lack of knowledge and interest of rural people are important factors. Superimpose on this the fact that modern medical care requires association with hospital facilities, elaborate and expensive equipment, opportunities for consultation and specialization. The opportunity for study and keeping in touch with advances in medical science is another important element in this concentration of physicians in or near urban areas.

Moreover, medicine- profession though it be- must render unto its members a living wage, opportunities for living standards which will enable the members to carry on a high grade of service, strength, energy, and incentive to advance the science; and opportunities for education, recreation, and the like, for wives and children. True it is that some of the medical profession receive large fees and incomes, but so do men in other professions and in business. As long as there remains inequality in wages, how can we expect the medical expert to refrain from wishing to claim his share ? Medicine should not be blamed more than other professions, business or politics. Politics certainly has proved to be a fertile field for many people.

On the other hand, excessive fees asked by many specialists have been a vital factor in the lack of adequate

medical care for middle-class people. This has helped in creating the hue and cry over group medicine and the demand for it, and even for state medicine. The medical profession itself, or its specialists, have helped to create a definite problem for the existence of the individual general practitioner and family physician.

Part III- The Cost of Medical Care A Problem.

The cost of medical care looms as a 'bug-a-boo' in receiving adequate medical care. The poor receive far less than they need, even though what they receive is charity. The wealthy may receive all and more than they need, but they are charged exorbitant fees in order to help cover overhead costs, unpaid bills, and straight charity. The middle-man, to a great extent, goes without medical care. The farmer, even if he can pay, may be too far from medical care to receive that which he might afford. The whole tale is that of receiving inadequate care, a few paying for their own care and that of others, and the majority receiving far from the essential amount of care required.

The physician's cost of giving medical care has steadily increased with the advances of medical science. He has a right to a living wage, and security for himself and his family. He gives liberally of his services to charity, both willingly and because he is obliged to do so, often through hospital connections. Is it fair that the medical profession should have to assume such a large share of charity, of tax upon their earning capacity,which no other group is expected to give ? Is it right that the rich should be asked unreasonable fees for normal illnesses ? Philanthropy has its place, but why force people into it under false pretenses ? 'Charity begins at home', applies to the poor or

middle-class physician as well as to the same financial group in any other field.

Adequate medical care is an essential for the progress of civilization. Medical care which involves: preventive care; care of the temporarily ill; care of the chronically ill; immunization; maternity care, and reduction of infant mortality; care of the mentally ill; care of contagious diseases, with the hope of the eventual elimination of such diseases; care of the crippled and the blind; these are all a part of the nation's need.

It is a large order, and how will it be met ? How shall we meet the medical needs of a nation whose life expectancy in the last 40 years has risen from forty years to sixty-five years of age ?

CHAPTER III

NATURE OF PRESENT INNOVATIONS IN RESPONSE TO THE SITUATION

We have seen that the purchase of medical care is largely a matter of private, individual action, although local, state and federal government spend considerable sums. Industry and philanthropy also contribute to the nation's bill for sickness. In spite of all this, the individual carries the principal share of costs, through his private payment to doctors, dentists, hospitals, laboratory, and nurses.

We are now spending an average of $22 and $25 a year for each person for all forms of medical care. We are told that out of a family income of $1,200 a year, there will be spent for physicians and hospitalization $36; for an income of $1,500, $45 will be spent; for a $2,000 income, $60; for a $2,500 income, $75; and for an income on the $3,000 level, $90 will be the average spent.

How then can we use these known expenditures of people, and the known elements of medical care to bring about adequate care for the population as a whole ? Social evolution lies behind the cause of this condition of medical care, and the solution seems to be 'to bring the physician, the patient, and the dollars into such harmonious relation with each other that the practice of medicine can keep pace with the science of medicine and with the needs of the people.

Medical care is now costing us over three billion dollars a year,-almost three-quarters as much as we spend to ride around in

motor cars. If we abolish the reducible wastes in our present methods of paying for and supplying medical care, this would supply much more good medical service to many people who now get little or less than they need.

One important factor in financing medical care is to remove the hazard of unpredictability in so far as possible. A large voluntary budget allotment each year in middle-class families would be an important item for covering this hazard, especially if all funds not needed in one year were duly harvested and put aside as a permanent fund for medical care. The average person is loath to do this; new radios, new automobiles, relatively expensive vacations or pleasure trips prove to be more appealing. Since human nature is loath to, or finds it extremely difficult to save for and against the unknown and the unpredictable, and because it turns its back on thinking about possible misfortune or sickness, other means of providing for medical care have arisen.

Care of the indigent, care of the tuberculous, of venereal disease, of cancer, maternity care, and prevention of contagious disease, along with sanitation, living wages, food, housing laws and the like, may rightly belong outside the care of individuals in whole or in part, but what of general sickness and accident care ?

To meet the needs of that great majority, perhaps 80 per cent who could plan to pay their bills if they had the average amount of illness, or if that amount were predictable and not suddenly vastly more than their income allows, several plans for

group medical care have been organized. These fall into two types: non-prepayment and prepayment.

Part I Non-Prepayment Plans

(1) Clinics and Out-patient Departments

Clinics attached to hospitals, private philanthropies, and medical schools have increased markedly. The indigent have always been provided for, but these clinics have developed to provide care of all kinds to people-not only to those who cannot pay, but to those who can pay a small fee. Too often, people who can pay adequate fees use these clinics which are really not meant for them. In some cases, they do not know how to choose a physician, and in others,- far too often- they see no reason to pay more for services which they may acquire for less. Moreover, organizations for determining the ability to pay are usually not well developed by these institutions, and chiseling is an easy matter.

The medical staffs, except in cases of local, state or philanthropic clinics are volunteers. Young men are supervised by older men in their special fields. The load carried by these clinics is apt to be great, so that individual patients may or may not receive adequate care. They may go away with the feeling of having been slighted, when actually they have not been. The interest of the physician will vary with that individual, his interest in humanity, his already overcrowded schedule, and his need for experience. Some groups have gone so far in this matter of clinics, especially in the matter of tuberculosis and child health, as to have a mobile hospital-units which go to rural areas

at given times in order to bring the doctor, his assistant, the nurse, and medical equipment to those who cannot come to him. In other words, a hospital clinic on wheels has been part of the development.

(2) Fee-For-Service Clinics

This type of privately-owned clinic has been in operation for many years. The oldest outstanding examples are the Mayo and Crile clinics. The Leahy Clinic in Boston is well known - at least to New Englanders.

This type is a fee-for-service sliding scale of payment clinic to which people go of their own accord or on the recommendation of their own physician. The functions range all the way from physical examination check-ups, complete surgical and hospital care to hotel accommodations. Some clinics like the Leahy Clinic have no hospitals of their own, but are closely linked with hospitals nearby. Likewise, they give little or no home care, but refer such care to a general practitioner.

The Mayo Clinic goes the whole way with a large set-up of hospitals, hotels, and advanced graduate study. The physicians, specialists in their fields, as well as all employees are on regular salaries, commensurate with other income for similar work. The patient interviews a financial secretary, and the clinic bills him according to his means, for all services rendered. The patient receives the benefit of complete and expert advice in all fields pertaining to his case, without being obliged to pay separately for services of specialists and without having to consider the financial arrangement as a personal factor between two individuals.

Consultations are freely held with any doctors within the group. Reports of all consultations, tests, etc. are sent to the physician who is given charge of the case. He, in turn, interprets these findings to the patient. He also supervises the care of the patient in the hospital, and his re-checks, whenever or if, the patient wishes to return.

This type of clinic is meeting an important need in the middle-class field. Expert diagnosis and care are afforded people at a figure which they can meet. The general practitioner is saved expense of vast laboratory equipment; the specialist has all the facilities at hand, and does not have to worry as to expense to the patient. The patient has specialists in consultation as needed, without running up impossible bills, irrespective of his ability to pay. More people are turning to this type of clinic with deeper and more sincere appreciation.

The physician, in addition to complete equipment and consultation aid, is relieved of all financial strain and worry, and is associated with the latest which medical science has to offer.

Part II Prepayment Plans.

Prepayment plans of insurance against medical care have developed along the following lines:

(1) Voluntary Health Insurance-Under Commercial Insurance Companies:

A. Individual and group health

B. Accident and dismemberment

C. Group hospital

(1) Voluntary Health Insurance

Commercial insurance companies, industry, independent groups of physicians and laymen, medical societies as well as the state have given impetus to plans for voluntary health insurance. Commercial companies, industry, and fraternal orders were the first to develop this type of care, with the so-called non-profit plans being of more recent origin. The advance of industries into the machine age brought with it many problems of accident during employment, disease caused by employment, and illness during employment. Who was to be responsible for accidents and sickness caused by employment ? With the loss of personal relationship between employer and employed, this responsibility became a question. The Workingmen's Compensation Laws of the various states created a demand for insurance coverage. Appreciation of the relation between illness, injury and productivity of the worker both to the employer and the employee added to this question of responsibility and provision for good medical care.

A. Commercial Insurance-Individual and Group Health.

Individual insurance companies have for many years offered insurance against sickness, accidents, and dismemberment, as well as against life and death. While some people have availed themselves of this type of protection, the large majority have found it not so attractive. Preliminary physical examination, high premiums, restrictive clauses, and cash indemnities which may seem hard to collect, have lessened the attractiveness of this form of insurance. Having paid premiums for several years from which no benefits had been received, due to lack of sickness, the individual loses interest and sees no reason why that amount

of his already scanty income should be apparently wasted. It is one thing for the individual to keep up payments on a life policy, for death is a definite state which will catch up with us all eventually, but sickness may or may not, If it does, will it be the kind included in our policy ? The gamble loses its appeal for many people. The principle of this type of insurance is premiums paid, cash reimbursements paid out to premium holders when proof of illness, accident, or what is covered by the policy is given; all expenses of sickness are carried by the individual and paid by him. This method assures or insures the patient neither against adequate care unless he himself makes sure that he receives it, or adequate reimbursement. He must choose his doctor and his care. The doctor is not insured against payment. The subscriber may receive his stipend, but may spend it for other than the purpose intended. The stipend may only crack the cost of the illness it needs to cover.

People are inclined to regard this plan of prepayment as expensive because it is carried under a commercial concern. The belief seems to be that all insurance companies are commercial concerns in which the stockholder owners must receive dividends. In reality, a large percentage are mutual companies in which all profits are returned to the policy holder as dividends, and applied to reduce the premiums.

The public assumes that all insurance companies must be run for a profit, and that, since large participation in individual health insurance is relatively small, the costs of writing such insurance is proportionately high. This factor

of spread and coverage applies to all the costs of all types of prepayment plans whether in profit or in non-profit organizations. Thus the argument against insurance in commercial companies loses much of its validity.

B. Group Health Insurance

This type of insurance increased rapidly previous to the depression, and is once again on the increase, due to the speed-up of war industries and to the expansion of many small factories into the war production field. During the depression years, as one might expect, many lapses in keeping up this type of insurance were bound to occur. People are always hesitant to keep up expenses for which they see no obvious returns. Hard times, pressing budgetary needs mean that anything which appears to be a luxury, is dropped, both by individuals and by concerns.

Group health insurance is open to employed people who insure as a group from a given concern, educational or similar institution. The premium is lowered according to the size of the group, the care covered, the age of the group, and the type of occupation. The premiums are paid partly by the concern or organization in which the group is employed, and partly by the members themselves. Cash indemnities are paid to the individual who, as we have shown, may or may not receive adequate care, and whose care may or may not be adequately paid for. Usually, a preliminary physical examination is not required. As people drop this plan, the rate increases, and often the company will refuse to continue insuring the group. This plan, while it may and often does, prove a help to the individual who is ill, it may

also prove a big drag on the middle or low income group. It may also offer little protection to the physician.

Both these plans of voluntary health insurance, whether individual or group, vary in coverage as to physicians' care, hospital care, surgical and orthopedic care, and dismemberment reimbursement. Some carry cash indemnity for time lost during work and a fixed sum if total permanent disability occurs.

C. Group Hospital Insurance

This plan is similar to those previously discussed. Only employed groups, sufficiently large, of average age spread, and without need of previous medical examination, unless a specific clause so stipulates, are eligible. The premiums must be paid partly by employee and employer, and are usually sent directly to the insurance company, thus making a lower rate possible.

The benefits are available to the employee and to his immediate family, if the policy so states, and the extra premium is paid. The policy usually provides certain definite hospital services, but does not include surgery and physician's care, nursing care, drugs or appliances, It may carry provisions for laboratory, operating room, and anaesthesia.

As with all commercial policies, the cash benefits or indemnities, are paid directly to the individual on proof of hospitalization, and he, in turn, pays the hospital. In this way, he is supposed to be able to make sure that he receives that for which he pays, whereas, if the indemnity went directly to the hospital, he might be charged, and the company might pay for facilities not given to him. This is one of the arguments of the

insurance companies for the commercial type of policy versus that of the so-called non-profit organization.

Since only large employed groups are allowed to join, the spread of risk is greater, and the commercial company may be able to write a more complete policy for the same or less money than can the non-profit group. This, together with the fact that both employer and employee must contribute, tends to keep the premiums assured and, in turn,make better rates possible.

We have previously shown that while this type of cash indemnity tends to protect the individual holding the policy, it does not assure him of adequate care, or the hospital of payment.

Before closing this discussion of commercial insurance, let me say that group policies may be written separately for different phases: sickness, accident and dismemberment; hospitalization; or for various combinations of these services. This plan of insuring under commercial companies has been followed by some concerns as a way of meeting the various state laws regarding Workingmen's Compensation.

The employer is relieved of all responsibility at the time, and the employee receives, or is supposed to receive, adequate care. In 1940, the Great Atlantic and Pacific Tea Company made arrangements with the Travelers' Insurance Company- a stockholder's company- for a program of group hospitalization insurance, including surgical benefits. Thus we see the use of this type of insurance by a large grocery concern.

"As a rule, the schedule of benefits is so arranged as to relate the amounts to the premiums which have been paid. Furthermore, there are usually maximum limits set to the amount that will be reimbursed for hospital or surgical services, and for the total annual indemnity allowed." 26

26. Goldman, Franz, M.D. Prepayment Plans for Medical Care. Joint Committee of Twentieth Century Fund and Good Fund and Medical Administration Service. N.Y. 1940, p.14.

CHAPTER IV

PRESENT INNOVATIONS

Part I. Non-Profit Programs of Group Practice.

Various programs have been organized to help cover medical care on a non-profit basis. These plans have been the outgrowth of the changes in economic, professional, and population structure. The expansion of industry, with its added responsibility to the employer for the health of his employees and for the productivity of his organization- which is materially lessened by accident, sickness, and chronic illness,- was a starting point. The desire of people to receive medical care for which they might plan to meet the cost was another incentive which was met by the medical profession through plans of co-partnerships and insurance. The needs of other groups led to the formation of cooperative societies, especially to take care of large groups employed in cities, and at the other extreme groups in rural areas. Let us examine in more detail some of these plans.

(1) Industrial Plans for Medical Care.

The realization by the employer that better health of the employee made for greater productiveness and fewer days lost through sickness, accident and disability, combined with the Workingmens' Compensation Laws in most states, caused many employers to set up Health Services within their own plants. These are paid for in some cases partly by employer and employee, and in a few cases entirely by the employers. The plans va-

ry from elaborate programs covering the worker and his entire family, entitling them to all medical and hospital service including home care, maternity care, and dental care, to merely care of employee for accident or sickness while on the job. The wider the service the greater the cost to individual and to employer. Often,too, those employees above a given salary level are excluded from participation in the service.

An illustration of the type of organization where the employer pays all is the Endicott Johnson Workers'Medical Service.

a. The Endicott Johnson Corporation is a large and prosperous corporation in Binghamton, New York, engaged in the manufacture of shoes and the tanning of leather. This service, inaugurated in 1913 in an effort to meet the requirements of the Workingmen's Compensation Law of New York State, provided at first only first-aid to injured workmen. Care for industrial injury and ordinary sickness are now included. "There are four medical centers, two maternity hospitals, two nose and throat hospitals, all fully staffed. In addition, employees are cared for in local community hospitals, at the expense of the company. No monetary contribution toward the cost of this service is made by the employees." [1]

The concern employs a full-time staff of more than 100 people,-among whom are 40 physicians on full-time salary. These salaries compare favorably with the average earnings of physicians in similar work according to whether general prac-

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1. Williams, P. The Purchase of Medical Care Through Fixed Periodic Payment. New York: National Bureau of Economic Research, Inc. 1932, p.22.

titioner or specialist.

"Complete medical service-including home, office, hospital, dental, maternity care, and drugs - was offered to employees and to their dependents. The employees were under no compulsion, and might utilize the service or consult their own physicians, as they wished. In practice, nearly 94 per cent of the employees use the service, either in whole or in part. Probably, over 80 per cent use the service exclusively."[2]

"The average direct cost of service rendered was approximately $17.31 per individual in 1938."[3]

Such an extensive type of plan can be provided only by a large and well-established concern. The cost is heavy, but the benefits to the employees and their families, and thus to society, are great. The cost borne by the company is indirectly borne by the consumer of the company's goods. The consumer unconsciously pays for complete medical service to persons in the lower brackets without the principles of insurance or collection of funds through taxation having to be employed.

b. Dr. Bray speaks of the results of a similar service carried on by the American Cast Iron Pipe Company, which has been in operation for approximately thirty years, and which has grown so much that it offers complete medical care free to all -including maternity and visiting nurse services, in these terms:

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2. Cabot,Hugh,M.D. The Doctor's Bill. New York: Columbia Press, 1935, p. 85.

3. New Plans of Medical Service. Bureau of Co-operative Medicine , New York: 1940, p.24.

"1. Our experiment has shown that a program including family rather than workers alone, is best.

2. We are able to provide our employees and their families with all the medical care they need, at a reasonable per capita cost. There is no doubt that our families would be unable to buy the same amount and quality of medical care provided in our set-up, if they had to pay for it on an individual basis.

3. Our loss of man-day illness during 1940 was only .87 of 1 per cent; less than one-half the national average of 2 per cent.

4. The number of days lost from accident in our plant is only .73 of 1 per cent, which is far below the national average. The general state of health and emotional stability of an employee primarily growing out of sound home conditions reduces the number of indirect accidents in a very significant way.

5. We feel that the working efficiency of our employees is increased to such an extent in terms of unit production, that far more money is saved than the total cost of all of our medical services.

6. We believe that the immediate and continual availability of adequate medical services to our employees increases their efficient working life span....In the field of prevention of chronic disease alone, our medical service program is fully justified.

7. Our medical service program is enabling us to make a more helpful and efficient contribution in the defense of our nation and in the stability of its economic and human resources than would otherwise be the case." 4

4. Bray, C.B. An Industrial Medical Care Plan. Medical Care autumn, 1941.voll. no.4, p.346.

What more need one say regarding the social values of such a plan ?

Less inclusive plans and plans involving partial payment by employees carry similar values depending on the extent of care covered and the premium charge to the employee.

(2) Prepayment Plans by Medical Societies and Other Groups of Physicians.

a. Group Hospital Service Plans:
(endorsed by the American Hospital Association in 1933).

This type of plan has had enthusiastic reception with a steady growth in the organization of the plans since the establishment of the first one in 1929, and a rapid increase in the number of subscribers. This plan is strictly limited to providing hospital care for a certain period of time. Physicians' services are not included, nor are all services directly related to hospitalization.

1) The usual provisions in this type of service are illustrated by the plan of The Associated Hospital Service of New York, founded in 1935, whose membership in January, 1939, was 1,100,000, and still rising rapidly. Our own Boston Blue Cross is another example.

In the Associated Hospital Service, care is provided as follows: "semi-private accommodations, or credit for private accommodations are furnished up to 21 days in each contract year, together with general nursing care, anaesthesia, if administered by a hospital employee, routine dressings, and standard drugs. Sixty days' additional hospitalization is permitted at a 25 per cent discount on the hospital's regular charge for semi-private

accomodations.

"The plan also includes the cost of operating room use up to $25; laboratory examinations up to $20, and diagnostic X-Ray service up to $25 in each contract year. After a waiting period of eleven months, subscribers enrolled in organized groups with family contract, may receive credit of $5 a day for a period of ten days toward the cost of maternity services. After a six months' waiting period, persons older than twelve years, may receive two days' hospitalization for the removal of tonsils and adenoids. For children under twelve years, hospitalization is limited to twenty-four hours. "[5]

The details of each hospital plan vary as to coverage, service rendered, and cost, but in general the following plan is applicable:

1. limited to groups where the individual pays all the subscription or the subscription is shared by individual and employer.

2. family coverage is included at slight extra cost, depending on the number of dependents.

3. the annual membership costs range from $5 to $13 per subscriber; the cost depending upon the type of service covered.

4. admission for the subscriber to any of the 'participating' hospitals when necessary, but only under the care of a private physician selected by himself.

5. physician's fees, and all hospital bills not stipulated in the plan are paid by the subscriber.

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5. Goldman, Franz. Prepayment Plans for Medical Care. Boston: Edward A. Filene Goodwill Fund, 1941, p.12.

These plans have largely benefited the middle-class group, but most hospital service plans have or are incorporating ward plans to help cover those groups for whom this care is not possible, and who are not in the lowest income bracket, and thus eligible for charity care. This plan helps only a certain group to cover only a certain portion of unexpected medical service, and is not alone the solution of our problem for adequate medical care at a reasonable rate. Also, there has been a tendency to limit the amount of coverage, as experience has increased and has shown weaknesses in the system. One vitally important factor for the success of this plan is a very large subscription membership.

(3) Provision of Physicians' Services by a Non-Profit Organization.

These plans vary in different parts of the country both as to range of income group and range of services. Some plans include medical, some, medical and hospital combined. The limitations imposed vary with each plan.

a. The Western New York Medical Plan, with headquarters at Buffalo," offers limited physician's services to subscribers of below $1,800 income at a cost of $18 per year, with lower family rates; but the first $10 of medical expense must be paid by the subscriber before he receives benefits under the plan. The total indemnity may not exceed $450. Chronic and certain other illnesses will not be covered."[6]

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6. Davis, Michael M. America Organizes Medicine. New York: Harper and Brothers, 1940, p.155.

"Couples earning up to $2500 and families with children under 18 years of age are eligible, provided the combined income does not exceed $3,000."[7]

Thus, charges range from $1.50 a month for an employed subscriber to $2.25 for a couple and $3.00 for a family which chooses the so-called medical and surgical plan with obstetrics. Group enrollment is a prerequisite in this plan.

This plan helps people to budget, but it also involves super-charges at definite rates. This is for the protection of the medical profession who must have some means of preventing abuse of the low-cost systems of medical care.

b. Ross-Loos Medical Group of Los Angeles, California, combines group practice with voluntary health insurance. The group is organized as a co-partnership in which 19 physicians on the staff, including Drs. Ross and Loos, form the co-partnership which owns and operates the clinic. The group is operated by a staff of more than ninety full-time, salaried physicians. It offers "complete medical service, including house calls, diagnoses, medical treatment, surgical treatment of all kinds, eye tests, and hospitalization. Members receive all services and supplies free, except eyeglasses and certain types of expensive medicines. The costs of the service are $2.50 per employed person per month."[8]

In addition, dependents of members are allowed to receive all professional services at a nominal charge, but are required to pay for hospitalization and for certain supplies or

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7. Goldman, Franz. Prepayment Plans for Medical Care. Boston: Edward A. Filene Good Will Fund, 1941, p.15.

8. Foster, W.T. Doctors, Dollars and Disease. New York: Public Affairs Pamphlet No.10, 1940, p.17

apparatus.

"The average extra charges for home calls, hospitalization, medicines, and other extras for dependents is 81 cents per family per month."[9]

Each group of employed persons has a contract with the Ross-Loos Medical Group; applies through its representatives for membership in the group, and makes all the financial arrangements between the clinics and the group. All complaints and adjustments are taken care of through these health committees and no paid solicitors are engaged to sell contracts, no advertising is allowed and all material must have the O.K. of the physicians.

This plan has a large membership and has been rendering excellent service in spite of opposition. The fact that a group must ask to join and is not solicited makes the members feel more keenly a part of the whole plan and increases that important personal relationship factor.

c. The Middle Rate Plan of the Baker Memorial Division of the Massachusetts General Hospital, Boston, Massachusetts.

This plan was begun on March 30,1930. The Baker Memorial staff of physicians and surgeons agreed to render professional services at moderate fees, "with a stated maximum ($150) regardless of the type of case, provided that the hospital stay did not exceed three months."[10] The patient, on his part, agreed to restrict his expenditure for hospital and special nursing services to those required by medical necessity, as recommended by

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9. Ibid. p.17.

10. New Plans of Medical Service- Bureau of Co-operative Medicine New York, 1940, p.11.

the attending doctors. The hospital agreed to provide services at charges not exceeding their cost to the institution. The fees, medical and surgical, for each patient were to be determined by the attending physician in conference with the medical director of the hospital. The admitting office, by means of a personal interview, decided if a patient were eligible for care. The business office was to keep all financial records and to collect fees for and on behalf of the physicians and the special nurses.

"During 1938, the admissions exceeded 5,400 patients, and the average daily occupancy was 206---the average charge for all cases ---during this year was$177.51, including physicians' fees, and hospital care. The average length of stay was 14 days."[11]

This plan has been a marked advance in rendering care to the middle income group who can, and wish to pay. It has enabled the individual to budget his expenses, to receive good care. It has enabled the doctor to render care at less expense because he was sure of his remittance, even though individual remittances were lower than the usual schedule. Use of group equipment, group facilities and collection of bills through a central office have also helped to reduce the cost of service for the physician and the surgeon. The hospital was able to curtail its expenses through constant use of its equipment.

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11. New Plans of Medical Service - Bureau of Co-operative Medicine New York City, 1940, p.p.11-12.

d. Plan of the Joseph H. Pratt Diagnostic Hospital in Boston.

The Joseph H. Pratt Diagnostic Hospital, a unit of the New England Medical Center, was opened in 1938 under the ownership and management of the Boston Dispensary. The object was to offer to licensed physicians in New England facilities for the special study of the diagnostic problems of adults. Children under 12 years of age are not admitted.

No patient is admitted unless sent by a physician. The patient is discharged to the referring physician who maintains complete control at all times over the disposal of his patient. To avoid interference with the physician-patient relationship, all correspondence is entirely with the physician, and subsequent admissions can be arranged only through him. A complete report of findings, with diagnosis and recommendations is sent to the referring physician as soon as the data can be assembled.

The hospital has 43 beds available for the treatment of ward, semi-private, and private patients. Also, it has complete diagnostic laboratory facilities; electrocardiographic and metabolism rooms; X-ray department, and operating suite for technical procedures. Offices in the building are provided for the Senior Staff members of the Hospital. Lecture rooms, teaching and research laboratories facilitate the program of post-graduate education and hospital extension service, which are features of the institution's general program.

Patients are expected to make an advance deposit of $50, $75, or $100 on admission to the hospital. The average stay is from four to five days, and the estimated total cost is ordinarily

about twice the cost of room and care. Room and care vary from $4 per day for ward patients to $8-$12 a day for private patients. Laboratory fees are charged in accordance with room accommodations at the flat rate of $7.50 for ward patients; $10 for semi-private patients, and $12.50 for private patients. The fee increases to $12, $15, and $20 respectively, if a large amount of laboratory work is done.

Operating room fees range from $3 to $10; and charges for anaesthetist, X-ray examinations, electrocardiograms, basal metabolism tests, special tests and special medication are extra. In addition, a fee of $10 to $15 is charged for diagnostic services, and a written report of the case containing diagnosis and recommendations.

In October, 1940, the hospital opened a new consultation service for patients whose condition could be studied without actual hospitalization. In every way it is similar to the service offered in the hospital, but without entailing the cost of room and care.

A deposit of $25 is required of patients of limited means as a minimum admission charge. This includes diagnostic fee, all consultations, and the complete routine studies. X-ray examinations and special laboratory procedures and the like involve an extra charge, but such patients are guaranteed that the total charge will not exceed $45. The charges are slightly higher for patients of ample means.

This system provides an opportunity for a general physician to obtain expert diagnostic procedures for his patient at a relatively moderate fee to the patient, and at the same time returns the patient to the original doctor for care. The usual fee-for-service clinic tends to absorb the patient into its system rather than to return the patient to the referring physician.

e. Panel System

We cannot leave this picture without considering the Private Panel System. Several examples of this system have started out and have either had to withdraw for "the duration" or are now experimenting with plans of only partial coverage.

f. The White Cross or Health Service Incorporated of Boston has been one of those forced to desist "for the duration" due to the number of physicians enlisting in war service. There is also to be considered the important factors of an insufficient number of subscribers, thus making the payments received by physicians unduly small and, in turn, limiting the physicians in the system. This plan was opened to individuals or groups; and to individuals or individuals and their dependents. The charges for group plans naturally were lower than for individual and family plans. In general, the fees ranged from $15.00 for an individual to $55.00 for a family. The coverage was partial, due to restricting clauses in regard to serious illness, chronic illness, maternity care, home calls and such. Supercharges were also a part of the picture.

The patient had freedom of choice of a physician from any one of the doctors on the panel; that is, of those physicians who had agreed to associate themselves with this service.

The physician received payment on "the unit schedule". Thus he received payment from the service at regular intervals for service rendered, but only on a proportionate basis if insufficient funds had been collected by the White Cross. While

insuring freedom from collection of bills this low rate of fees is of questionable interest to physicians of much experience who might rather take their chance of more uncollected fees and yet greater total income.

This type of plan in working out has proved more ideal from a social standpoint than from a practical one, and many plans so started, as Michigan, Buffalo and California, are finding financial difficulties and are reducing the coverage offered. A large subscription membership is vital to the success of this plan.

(4) Consumer Co-operative Plan.

This type of plan is an outgrowth of the general co-operative movement which has been receiving increased momentum during the past few years. Under this plan, members own and operate the organization and have final authority over its policies. The organization employs and chooses the physicians who furnish the medical service which members want and for which the organization is maintained.

In order to make the medical care as effective as possible from the professional standpoint, the doctors must be well selected and satisfied with the conditions under which they work. To render the service satisfactory to the members, there must be active cooperation between the doctors and the members in the daily conduct of the service and in the administration of the organization.

a. The much 'fought over' Washington, D.C. Group Health Association is a good example of the type of plan. More than 3,000 people, employees of 50 federal agencies, are members.

Together with their dependents they constitute a body of over 7,000 persons who receive medical service under this association.

This plan was the culmination of a need which existed for large groups of people working in a crowded city which was not their original home.

"The costs or charges are $2.20 a month; wife or husband of a member $1.80 ; all children under 18,$1.00; children, 18 to 21, $1.00 each; dependents over 21, $2.20. Extra charges, $1.00 for first call in any one illness; $25.00 for delivery."[12]

There are special restrictive clauses for chronic illness, but otherwise, the service covers "physicians' services, laboratory tests, X-Rays, eye refractions, hospitalization, (semi-private accommodations) for 42 days in a year, 21 days in any one illness."[13]

The medical staff is on salary, but has access to outside consultants when necessary.

b. The Farmer's Union Co-operative Hospital of Elk City, Oklahoma, is an example of a cooperative applied to rural areas but unlike most cooperatives, those rendering the service- in this case the physicians- completely control not only the professional end of the work and are free from all interference or dictates from the laymen stockholders, but they also have as much to say in regard to their compensation as they would have in private practice. The Elk City plan is a cooperatively owned and managed

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12. Reed, Louis S. Costs and Benefits Under Prepayment Medical Service Plans. Reprint from Social Security Bulletin, No.3, March, 1940, p.9.

13. Ibid. p.9.

hospital and group clinic which provides its members and their dependents with complete medical and dental services on a flat monthly or annual fee basis. Minor supplementary charges are based on the services received. "All persons joining become stockholders in a non-cooperative association." A stockholder without dependents pays $12.00 per year; with one dependent, the rate is $18.00; for a whole family, of whatever size, the rate is $25.00 a year. Payments must be made quarterly in advance. Participants in the health service benefits are limited to the families of stockholders, each of whom owns a share in the community hospital.---The shares cost $50.00 each---used only to pay for hospital land, buildings and equipment. The stock is not assessable, but stockholders must pay their share in full when hospitalization is received."[14]

Residents in the community may also use the medical, dental, and hospital services on payment of regular fees charged for similar services in the community; and there are several other physicians in the country.

Out of every $25.00 subscription, $12.00 goes to the medical and dental staff, and $13.00 is applied to hospital expenses. All fees from non-member patients go directly to the attending physicians or to the hospital, respectively. The fees are assessed and collected by the business office. One month's vacation with pay is granted to all members of the medical staff.

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14. Rorty, James H. American Medicine Mobilizes. New York: W.W. Norton & Company, 1939, p.281.

This cooperative received much condemnation from the medical profession, but persevered and has contributed real medical care at a reasonable cost, not only to its members but to non-members in the vicinity. It has enabled many people in this area to have care through depression and drought times which would otherwise have been inaccessible to them.

(5) College and University Health Services.

A large number of American colleges provide medical care for their students. Some have extended this service to their faculty and office employees. The method of payment varies, in some cases the charge is in addition to tuition, in others the tuition includes it. The extent of the service varies from free office care to so many weeks of hospitalization. Some colleges are even carrying on group hospital plans with commercial insurance companies in addition to their "on campus" medical service. One of the striking advantages of this college health service plan, according to Dr. Warbasse, is that students tend to go for examinations when they are relatively well, and to seek advice before they become seriously ill. Another advantage is that of education in the preventing of disease and in caring for illness before it has fully developed. Good medical service provided at a moderate cost to intelligent young people ought to serve as an incentive for maintaining and conserving their health, and for seeking adequate service whenever it may become needed.

(6) Plans Under The Aid of the Farm Security Administration.

"Four and one-half million farm families which equals three-quarters of the entire farm population of the United States had

net cash incomes of less than $1,000 in 1940."[15]

The Farm Security Administration found that a sick farmer is a poor credit risk and that slow, nagging ailments cut productivity. An unpredicted emergency operation resulted in wiping out a year's income in a few days, and all hope of paying off a loan vanished. A large part of all loan defaults were due to sickness.

In 1936, the Farm Security Administration decided that "adequate medical care for its clients would be sound financial policy as well as an investment in national health."[16]

Although you cannot predict how often sickness will strike any one family, you can estimate the amount of sickness that will probably strike a thousand families. On this basis of reasoning, the Farm Security Administration inaugurated a plan where a large group contributed to a pool from which funds to pay private physicians for treating subscribing families were to be taken.

Details of the plan were worked out by the physicians through their county medical societies. Medical Care Magazine for January, 1942 shows that in a typical local plan the following policies are used:

1. Group payment in which the annual amount for a family ranges from $18.00 to $30.00 or more, depending on the part of the county and on the extent of the service offered.

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15. "Medical Care Under the Farm Security Administration", Medical Care, January 12, 1942 Volume 2, No.1, p.79

16. Ratcliff, J.D. "Health for the Backwoods", Readers Digest, Vol.43 No.243, July, 1942, p.69.

2. The funds from each family are placed in a pooled or common fund. This is placed in the hands of a bonded treasurer or trustee.

3. Payments are made to the physicians, hospitals and druggists from the quarterly or monthly allotments paid in.

4. Participation of families is voluntary.

5. The Farm Security Administration loans the family the amount required to supplement what the family cannot pay out of its own earnings.

6. Service is provided by the local physicians, and the basic services are what can be provided by local general physicians.

7. Many localities have special arrangements for especially needed surgery and hospitalization. The number of such areas is increasing.

8. Arrangements for some dental care are growing.

9. These special services often have to be obtained from outside the area.

10. The enrolled borrowers have free choice of any physician, from those participating in the plan.

"Farming[17] is one of the most hazardous of all occupations. --A recent Farm Security Administration survey shows that only 4 per cent of its clients are in prime health; 96 per cent average three and one-half defects each-bad eyes, bad teeth,hernias,

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17. Ratcliff, J.D."Health for the Backwoods", Readers Digest, Vol.43, No.243, July, 1942, p.72.

malnutrition, and so on. In Texas and Oklahoma only one out of every three deliveries was attended by a physician."

The Farm Security Administration is still experimental in many of its phases, but it offers a possible solution to a nation-wide problem. "Today it serves 110,000 families in 1,000 counties, one of the largest groups in the world organized under a voluntary medical care program."[18]

Already it has meant that farmers reluctant to incur debts which they could not pay, are receiving through government loans care for which the doctor is paid. Minor ailments formerly grew into major ones and often fatal ones.

Doctors are being paid real cash and are collecting 89 per cent of their bills. They are paid promptly if not liberally. Moreover, the farmers are not abusing the privilege of good service for low fees. Hospital and maternity care are now possible.

The whole picture is a boon to the rural population. A healthier farm population in the long run means a healthier future generation as a whole. The repopulation of our country depends more on the country than on the city family where the percentage of children is small.

Only one question remains. Will this really prove to be a government loan or a government subsidy supported out of tax funds ?

(7) The Salaried Physician.

Still another method of financing medical care in some rural areas is that of the salaried physician. Isolated communities alone or in combinations of two or three communities fairly near

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18. Ibid. p. 72.

together have hired a physician to come and provide medical care. A regular salary is paid from the local tax funds of the people, thus insuring the physician a minimum salary. In addition, definite prescribed small charges are allowed for home and other special services rendered. If a maximum salary is given, no extra charge is allowed. This enables young doctors to go out into rural areas and keep body and soul together. At the same time, the people are furnished with a care which otherwise would not be available to them.

Many plans for the organization and payment of medical care under these various groups have thus been instigated to meet this great need of our people at various income levels. The success of the plan varies with the conditions under which it is organized and operated. All have some, if not many, good points, in their favor.

CHAPTER V

ADVANTAGES AND DISADVANTAGES OF GROUP MEDICAL CARE.

Group medical practice means the "application of medical service by a number of physicians working in systematic association, with joint use of equipment and technical personnel, and with centralized administrative and financial organization."[1]

(1) The general objectives of all group medical practice whether under fee-for-service, or prepayment plan, are resolved into:

1. Increased efficiency from the professional standpoint in the conservation of health.

2. Increased efficiency in the diagnosis and treatment of disease through the close association of several physicians and the coordination of their different skills.

3. Increased efficiency through availability of adequate, extensive, and up-to-date equipment.

4. Realization of definite economy of service to patient, physician, and hospital through efficient organization of services, facilities, and supplies.

5. Satisfaction to the patients through the accessibility of adequate or complete medical service through a single, central organization.

6. Satisfaction to the patient through the continuity of relationships between physicians, and between physician and patient.

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1. Medical Group Practice: (Committee for Study of Group Medical Practice) New York: Committee on Research in Medical Economics, 1940, p.6.

7. Compensation for the physician through definite salary or schedule basis, and freedom from bill collection.

8. Compensation for the physician through opportunities for adequate facilities, work and consultation.

9. Compensation for the physician through opportunities for research, study, and professional advancement.

(2) The objections raised to this type of practice have come largely from the American Medical Association which, for years, has waged a fight, more or less violent as occasions arose, against group medical practices on the prepayment level. It has always recognized the value of the free clinic and of the private fee-for-service clinic run on high medical standards.

The chief objections to prepayment group medical programs have been along the following lines:

1. It means the regarding and selling of medical care as a commodity, not as an individual service. Medical care is not a commodity to be purchased over the counter. It is an individual, personal service.

2. It removes the intimate patient-physician relationship so vital to good medical care. This need be no truer of group practice than of individual practice. It is largely a matter up to the individual physician or group of physicians. An individual doctor may or may not maintain a vital personal relationship with his patient. If the patient is sent on a round of visits to separate specialists, he is apt to feel that he is merely a guinea pig. His private physician may or may not

correlate the findings. The group clinic claims to plan for such correlation.

3. The cost of adequate medical care is not reduced, for many patients do not need the expenses of a complete clinic set-up. They do not need to be put through routine examinations and tests, when all that is needed is simple diagnosis and advice. It is claimed that necessary immediate medical help is often retarded or postponed, due to the prevalence of lengthy diagnostic and test periods. The average individual does not need the full facilities and equipment required for adequate, complete group service, and should not be asked to carry such cover or overhead charges.

4. Freedom of choice of physician is another objection offered. Here again, as with personal relationship, the objection cannot be fully maintained. In an urban population where one knows little of his neighbors, and probably less about its doctors, one chooses on the basis of accessibility, the opinion of someone else, according to the telephone directory, or the sound of the name. When it comes to choice of a specialist, that is usually purely on the recommendation of the general practitioner or because he seems to be famous. In rural districts, choice is limited to the local physician or to sufficient funds and travelling facilities which enable one to seek aid farther afield.

5. Unfair competition seems to be a valid objection. The group as an organization may advertise. This privilege is refused the physician. It is against medical ethics to advertise

for business. In spite of this, some physicians seem to do a pretty good piece of work along this line through social contacts; and through making the patients he does have so well satisfied or so well impressed with his powers that his reputation spreads. This may be deliberate, unscrupulous propaganda or it may be well earned reward. Is not the physician who deliberately tries to advertize himself in the class of those who sell a commodity rather than in the class of those who render a service ?

6. Lowered professional standards and lack of control over standards may result from this business-like type of organization for dispensing medical care. The economic ends, the partial control by business management may result, especially in consumer co-operative plans, in a tendency to lower standards, but is this more true among a group of physicians joined together in practice than it is for individuals or groups not so joined ? The lowering or raising of standards is largely an individual matter. The group may be high or low, according to the standards of the head physician. This, in turn, depends on the standards of the individual. As for control over standards, groups are made up of individuals and the American Medical Association or state societies still have the same powers to condemn or to approve.

7. The physician does not receive adequate compensation. This may be true in cases where no pay is received or only the top men receive large salaries. On the whole, it has been shown that a definite salary means adequate recompense in

the sense of financial security for the physician. In general, the salaries compare with those in individual practice. In cases where the amount received depends on the "unit schedule" fee basis, and on the collection of subscribers' membership funds, the physician often renders service for which he must later accept a very inadequate financial recompense. The unpredictability of the amount of this recompense lessens in no way the strain of financial insecurity involved in individual practice. Whether it be uncollected bills or uncollected full "unit schedules"- which to start with are always low- it presents the same problem.

8. In cases where membership or unit payments are low, it tends to cheap, inadequate medical care. Probably true !

Some of these arguments are valid, some are questionable, and evidently instigated by fear:-fear of change; fear of loss of practice; fear of control over standards; and fear of a profession being turned into a business.

Let us now consider, from these standpoints, some of the plans included in the preceding chapters.

(3) Advantages and Disadvantages of Previously Considered Types of Group Practice.

A. Clinics- free or for a small fee.

The clinic or out-patient department attached to non-profit hospitals, clinics under private philanthropy, or under state or local control, provide care for those not only in the lowest income bracket, but, in many cases, for people who can afford to pay much more than the small fee often charged. These clinics are important in the care of the needy, but their use is too often abused by the person who goes to a clinic to save his money. One wonders if he would accept such charity from physicians if presented to him in private practice. To be sure, training for the young, inexperienced doctor is provided in the clinic, but in other fields, the professional man is worthy of his hire, little though the remuneration may be. Moreover, the responsibility and supervision of such clinical care fall upon the shoulders of experienced physicians and specialists. These men are already overburdened, and yet they are expected to give time and energy to this type of charity. In governmental, state, or philanthropic clinics, small salaries are paid at clinic hour rates, or in some instances, a few are on full time salaries.

Economically, the expense to the hospital is heavy, the expense to the individual physician is rather presumptuous, while to the patient, it is little or nothing.

From the standpoint of service to the individual, that is a varying quantity, depending on the experience, interest, and time allotment of the physician. Inclusive care is possible.

The patient is sent from one department to another if the occasion demands, and if the clinic is in a large organization. On the whole, this type of service offered is of vital importance to the needy, but I believe it should not be open to those who are not actually in need of charity. For those in the lowest income bracket some means must be found to give them care in accidents and in sickness, whether through free clinics under private or state auspices, or through some other means, is the question.

B. Fee-For-Service Clinics.

These clinics, while relatively few throughout the country, are filling an important place for all people above the low income level. Expert care is provided, the advantages of medical science and research are available. The patient pays according to his financial ability. The physicians do not have to worry about income, for they know what security they have in the form of a definite salary. In addition, the physician connected with such a clinic has opportunity for research in his special field.

The cost of service in such a clinic can be reduced over that of individual practice for the general practitioner, and consultant specialist, because the expensive equipment and layout are combined under one organization. Thus, equipment is used on a full-time basis instead of merely part of the time. Technicians and laboratory assistants are used by a group, as are the waiting-room, office space, and clerical help. All these

factors go toward reducing the item of overhead which looms so large in individual practice.

The disadvantages are conceived as lack of the personal contact enjoyed in the relationship of private physician and patient, the lack of freedom of choice, and the fact that all too often an individual does not need the "complete works" but merely good sound advice, and the help any good general practitioner can give.

This last argument is a valid one, and, in some cases, individuals presenting themselves at such clinics do run up unnecessary expenses. On the other hand, when the general practitioner has recommended contact with such a clinic, the service for consultation purposes is greatly reduced from individual specialist fees.

Freedom of choice is rarely allowed in the case of picking a specialist, unless one just goes on his own. Usually, one takes the recommendation of his general practitioner. So actually, this argument loses its validity.

Personal contact seems to be maintained in this type of clinic by having one physician or specialist appointed to tie up all findings and be responsible for the care of each individual case; or the patient is returned to his own general practitioner for this work. Another argument against it is not substantiated.

This type of organization stands high in favor of meeting certain special needs of people in and above the middle-class. Moreover, it is a source of preventive care by its yearly check-up examinations of which people in middle life are beginning to realize the need. One might add that, in many cases, such a complete

and relatively expensive yearly check-up is unnecessary and an efficient examination might well be carried out by a good general practitioner, reserving clinic use for more specialized service.

As stated previously, it is not this type of group service to which the American Medical Association has raised objections.

C. Prepayment Plans.

In general, we may distinguish here between insurance plans written on a cash indemnity basis, and other forms of prepayment plans.

The whole principle underlying the idea of prepayment plans is that one may insure in part against unpredictable expenses which may arise, and which would be more than difficult to meet. Thus one need not go irrevocably in debt, or be compelled to receive charity, or do without. It provides protection for the physicians, surgeons, hospitals, and those who carry the burden of the financial insecurity of the patient.

Prepayment will mean that people will tend to prevent or check sickness before it reaches an advanced stage, thereby preventing: great cost; loss of working days; loss in productivity of the individual and an economic loss to the individual and to society.

D. Insurance Plans may be considered under the two headings of cash indemnity plans and non-cash indemnity plans.

1. The Cash Indemnity plan, as we have seen, provides the individual with cash payments on proof of sickness, hospitalization, dismemberment, or whatever the policy includes.

This plan may cover the full or partial cost experienced but its disadvantages, in the main, are two: (1) that the patient may not receive adequate medical care because he does not know how to choose it; (2) that the physician or hospital fails to receive payment because the money paid to the individual for the expense incurred is used for other things. The insurance company makes no check on how the reimbursement or cash indemnity is spent.

On the other hand, the cash indemnity makes it possible for the patient to know whether he receives that for which he is paying,because the bill is paid by him and not by an organization which merely receives a bill for supposed services rendered.

This plan of insurance, while excellent in its limited way, does not provide for anything but treatment of actual illness, nothing for preventive care. On the other hand, it may carry cash payment for time lost, due to sickness. When this clause is incorporated, it is a real boon to the individual who, through illness incurs not only expense, but loss of income. Thus, cash indemnity insurance may prove to be an asset in maintaining good home conditions, adequate nutrition, and freedom from financial worry.

2. Under Non-Cash Indemnity Plans we have:

a. Group Insurance which ,like all insurance, helps to protect the individual against unpredictable expense,and at the same time protects, to a given extent, the physicians or hospital providing the service.

The advantage of this type of insurance is that spread of risk makes possible greater service for less money. From the standpoint of the individual, or the hospital rendering care, the fact that a certain amount of business will be provided because insured people will tend to use that insurance makes for a certain sense of economic security.

One great disadvantage of all types of voluntary insurance plans, whether cash indemnity or group non-profit, is that when, over a period of years, no use is made of this insurance, the individual sees no need for continuing to protect himself and lets the policy expire.

E. Other Plans of Group Medical Practice.

The advantages of these plans to the patient are: the provision of partial or complete care under a definitely known financial schedule; at least a schedule within definite range of costs depending on what care may be needed; and an approximate estimate of extra expenses if they arise, is foretold.

The objectives are those of group medical practice in general, namely: to give increased professional efficiency in the conservation of health, and in the diagnosis and treatment of disease. This is to be obtained through professional association, adequate equipment, and the coordinating of specialists.

The patient receives satisfaction through continued relations with physicians and through the convenience of being able to obtain medical service all at one center.

Economy of service is brought about through efficient use of facilities and equipment, and because supplies may be purchased at lowest costs.

The physician receives proper compensation through salary, and at the same time, he has adequate facilities for his work, opportunities for professional education, and advancement.

The industrial type of plan in which the employer pays all costs of the service, which is organized as a special part of the work of the company, is of great benefit to the employees and to their families, where included.

It means, as Dr. Bray has said, greater efficiency on the part of the worker, less loss of man-days through illness, reduction in chronic disease, higher standards of living, and greater economic and emotional stability for the family and for the individual.

Are not all these important items in life for today ?

These same things hold true where the employee pays part toward the upkeep of the medical care provided. In addition, he is able to receive care at a low figure. The only drawback to this type of care is that the concern or company may endeavor to pass off an inferior grade of service in an effort to save money.

In cases where the employees themselves have made arrangements with a group of physicians for prepaid group care, this problem is avoided. The employees themselves are paying the costs, making the arrangements, having a voice in what they receive through the possibility of registering definite complaints. This arrangement

for group care seems to have all the advantages of efficient service from a coordinated group of specialists; economical use of facilities; adequate compensation for the physician, and the like.

In regard to cooperative plans for medical care, two great dangers arise: (1) that of running the organization as cheaply as possible, and thus endangering the quality of service; (2) too little control by the physicians who render the service.

On the other hand, this plan, if used by a large intelligent group, makes it possible to receive all the advantages of group medical care. It maintains and provides interest for members availing themselves of such care, and at the same time, makes it possible for them to meet the cost of such care.

Here again arises the disadvantage of the shareholder's interest in a business venture. It is necessary for its success to have good medical service and that success depends on the standards of the people and of the doctors employed.

We have previously seen that the Farm Security Administration plan has proved to be a boon to many rural areas, though in some it has not worked out so satisfactorily. The farmer who was far from care, both physically and financially, and thus a drain on society, has been able to meet many of his medical care problems, and to become a more efficient, more healthy, and more contented citizen, even if his borrowing limit and his loan load have been increased.

Group plans,as a whole, are meeting the needs of the middle and lower income groups in a more or less satisfactory manner. Experience shows that all these plans, except in some

cases where completely paid for by an employer organization, tend to be restrictive and to have supercharge attachments. This is necessary to make the financial side practical. Though risk hazard is lessened, the wider it is spread, too many unpredictable needs may not be included, without endangering the soundness of the policy. Moreover, some subscribers tend to abuse and overuse any membership privileges unless certain restrictions are placed thereon.

The plan so far presenting least satisfaction for the patient and for the physician seems to be the "panel plan". This is largely because of its wide spread of physicians, and because of the need for extremely large membership to make adequate medical service coverage and adequate recompense to physicians, practical and possible.

CHAPTER VI

SOCIAL, STATE AND FEDERAL PROVISIONS FOR MEDICAL CARE.

(1) Social and State Provisions.

During the past twenty years, local communities and states have taken great strides in preventive care; immunization; care of chronic diseases; maternity care; child health; and care of the mentally ill. General and special clinics, and state hospitals have multiplied. Statewide free examinations and laboratory tests, and hospitals for tuberculosis have been part of the program. State hospitals for cancer, for mental care, for the blind and the crippled, have been developed. Sanitation, housing laws, water purification, milk pasteurization, food and drug protection have been important features in the progress. Provisions for increasing the existing visiting nursing care and home care have been instituted, also school health programs.

In many ways, the public health programs have tended to extend, improve and coordinate tax-supported medical services to needy persons; to aid in enlarging and improving hospital facilities; to fortify and to facilitate contracts for voluntary health insurance; and to prepare the ground for compulsory health insurance.

Tax support of medical care has been developing along two fronts. Relief and better service are being provided for people who have little or no income through clinics, hospital care, and public nursing. On the second front, that of public health, the prevention and control of disease, the public medical

service has become more of an endeavor toward individual and social security than a humanitarian effort for the preservation of life and the lowering of mortality.

Once, the only justification for public medical services was destitution. Now, the increase in medical science and the economic factors involved, have made the spread of this service a necessity. The most obvious reasons for the growth of this provision for care, as given by Dr. Davis, in his book, Public Medical Services, are: "(1) that in mental disease, only public funds can make the provisions necessary for the large number of persons involved; (2) certain diseases, as tuberculosis, hookworm, and trachoma, frequently involve or lead to, incapacity for self-support;"[1] (3) in the case of acute communicable disease, public authority alone can provide care in a manner which will protect the rest of the community; (4)" in poliomyelitis and some orthopedic conditions among children and in early tuberculosis among young adults, the disease, if untreated, is likely to make permanent dependents of those who, with proper care, could be self-supporting;"[2] (5) uncorrected conditions of dental, eye, ear, and throat defects among children affect the education and usefulness of future citizens; (6) " the widespread interest in maternity and infancy places responsibility for them upon a public agency; and lastly, the costliness of diagnosis or treatment of such diseases as syphilis or cancer renders many self-supporting persons unable to meet the expense and eventually to become public charges or dependents.

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1. Davis, Michael M. Public Medical Services. Chicago: University of Chicago Press, 1937. p.117.

2. Ibid. p.117.

The degree to which local communities and states have developed their programs, has depended on interest of the people, on funds available, on state and federal laws and on federal grants-in-aid.

A local instance is given in the Medical Economics for March, 1942. Mayor Tobin announced:"Free immunization of Boston's entire infant population against whooping cough will be made possible under a $5,000 city appropriation for serum. The services will be available at 8 city health centers for all children who have not reached their first birthday. The program is to be extended to older children, if possible."[3]

(2) Federal Organization for Medical Care.

The federal government has assumed responsibility for medical aid for certain non-dependent groups such as: men in the army and navy; veterans and their dependents, under certain conditions; Indians, seamen and certain other persons in hospitals and clinics maintained by the United States Public Health Service; inmates, and in some cases, employees of governmental institutions-such as prisons; civilian groups in the Panama Canal Zone and in some isolated federal and state engineering projects; government employees injured in connection with their employment; and the general population in some rural areas, by means of health departments or through plans under the Farm Security Administration.

3."Cost-Free Medical Service Gains New Impetus" Medical Economics, March ,1942. p.83.

Public and federal interest in health also has grown markedly during recent years. The first White House Conference, in 1912, on Child Health and Protection aroused great interest, and the Federal Child Bureau was established. The Sheppard-Towner Act of 1921 provided federal grants to states for maternal and child health. The second White House Conference of 1930 carried further the plans for maternal and child welfare.

The Report of the Committee on the Costs of Medical Care issued in 1932, greatly influenced public thinking. This report carried recommendations along the following lines:

1."That medical service, both preventive and therapeutic, should be furnished, largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel. Such should be organized, preferably around a hospital, for rendering complete home, office, and hospital care."

2. "The extension of all basic public health services-whether provided by governmental or non-governmental agencies- so that they will be available to the entire population according to its needs."

3."That the costs of medical care be placed on a group-payment basis, through the use of insurance, through the use of taxation or through the use of both of these methods."... "Cash benefits, i.e.,compensation for wage-loss due to illness, if and when provided, should be separate and distinct from medical services."---

4."That the study, evaluation, and coordination of medical services be considered important functions for every state

and local community and that agencies be formed to exercise these functions, and that coordination of rural and urban services receive special attention."[4]

5. Various recommendations in regard to the field of professional education.

In 1933, the Federal Emergency Relief Administration authorized a program of medical care for the unemployed and their families. This plan lasted about two and one-half years. The general idea was to provide medical, hospital, and home nursing care under the auspices already available,- the cost to be paid for at a low unit rate.

The plan proved to be unsatisfactory in many ways, due to confusion of the resources to be used, of a definitely defined policy as to the care to be rendered, and to unequal and low standards of payment. On the other hand, some expansion in service was made. This was especially true in regard to home nursing service. The local communities and states as a whole have,in general, continued the plans for medical care put in operation during this period.

The Social Security Act of 1935 took the Federal Government out of direct relief, as,under the Federal Emergency Relief Program; it turned back to the states and localities the responsibility for the "unemployables" as far as medical care was concerned, on the ground that this was a form of direct relief.

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4. Rorty, James H. American Medicine Mobilizes. New York: W.W. Norton & Company, 1939. pp.337-338.

This Social Security Act developed the method of federal-state-local cooperation through equal grants-in-aid for public health service and for general health purposes. Also, organizationsfor maternal and child health were increased, with increased appropriations for aid to the state in the fields of the control of cancer and venereal diseases. The principle of equal appropriations by local community or by the state has often made these provisions for federal grants-in-aid impossible of realization.

Still, the Social Security Act has resulted in a considerable increase in public health services among which, according to Dr. Parran, is the increase in local health departments.

"In January, 1935, there 594 counties in the United States with local health departments, having the full-time direction of a medical health officer, and under the stimulus of federal grants on a matching basis, the number of such counties had, in 1939, reached 1,381, an increase of 132 per cent."[5]

This development has been of great aid to our rural population. Increase in hospital facilities, in the training of personnel, in research regarding cancer, in the control of tuberculosis and of venereal disease-have all increased during these last years.

The National Health Conference called in 1938,made up of people from all branches of the medical profession, public health, educators, and laymen offered further recommendations for

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5. Information Service, New York City, Department of Research and Education-Federal Council of The Churches of Christ in America, Vol.XIX, No.38, November 23. 1940, p.3. "Movements for the Extension of Medical Care."

and increasing medical care.

The five points in their platform were:

1." Expansion of our public health, maternal and child health services, with especial emphasis on preventing sickness.

2. Extension of hospital facilities, especially in small towns, and rural areas where free or low-cost hospital service is practically unobtainable.

3. Provisions for medical care at public expense for the one-third of the population in the lower income levels, unable to pay for adequate private care.

4. Measures for spreading the cost of medical care, either by state systems of medical insurance, or further extension of state medical services with the aid of federal subsidies.

5. Protection against loss of wages during sickness by insurance. Temporary disability insurance should be set up, as was unemployment insurance, on a federal-state basis; permanent disability insurance should be set up by amending the federal old-age insurance to pay benefits to workers who become disabled before the age of sixty-five."[6]

Bills, especially the Wagner bill, were prepared to help meet these recommendations. But the extent of control,the protests brought forth from the medical profession and from the people, have failed so far in the carrying out of all of these proposals.

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6. Amidon, Beulah. Who Can Afford Health ?
New York: Public Affairs Pamphlets, No. 27, 1939. p.29.

CHAPTER VII

PROPOSED PLANS FOR IMPROVING MEDICAL CARE

The war situation has developed many new problems. The rejection of many men for service, the need for protection of workers in defense industries,are bringing the situation of compulsory health insurance and of government control of health ever nearer. There are many who contend that health is as vital to the nation as education, and that, as education, fire and police protection should be provided free for those who need and care to use it, so, out of the pocket of the public-out of taxes- should come medical care available to all.

Will the war situation produce further governmental control, or will the excessive appropriations needed for war materials serve as a check on organization of medical care?

Among suggestions made for improving the organization of medical care in the United States are : Compulsory Health Insurance; and Community Medical and Health Centers.

(1) Compulsory Health Insurance, under state control, seems to the minds of some the only method for insuring adequate medical care. The idea is similar to that of social security. One more attachment would be placed on the pay envelope of the employed person. This deducted amount, together with a definite allotment from the employer would be handled by a state administration expressly devised for this purpose. To this sum would be added state or government funds

necessary to meet sickness costs, and, better still, cash indemnity payments during sickness.

The chief points for such a plan, proposed along more or less ideal lines, are somewhat as follows:

1. Since persons earning less than $3,000 a year are incapable of budgeting for illness, all people below this income group should be required to insure. Persons earning $3,000 to $6,000 annually, should be allowed to join, if they so desire.

2. The plan should provide cash benefits as well as medical care, for the economic difficulties are an important factor in hampering recovery from disease, in increasing poor living conditions, and in starting and ending the whole vicious cycle of events.

3. Maternity benefits should be provided, and should include cash benefits for a short period before and after childbirth.

4. Estimates are that such a system of health insurance would require about 6 per cent of wages. We have previously seen that that is a large proportion for a poor man's budget. This estimate means that the stipend "for the average weekly wage of $25 would be $1.50 per worker. Of this sum, three-quarters in necessary for medical care, and the remainder for cash benefits. The $1.50 contribution may be divided as follows: employers would pay 88 cents weekly for their employees receiving wages under $20 a week, 63 cents weekly for those earning between $20 and $40 a week, and 38 cents weekly for those whose wages exceed $40.---The employees' rates would be as follows: those earning under $20 would pay only 25 cents a week; receiving between $20 and $40 a week would pay 50 cents a week; while those with income above $40 a week would pay 75 cents

weekly. The federal government would pay into the fund an amount equal to 38 cents for each insured worker."[1]

The idea of proportionately higher stipends for the employer as the wage rate decreases is said to be fair because they benefit him through decrease in loss of working days due to illness of this group; which, because of its insufficient wages, has a high loss of time due to illness. Contributions by the employer are justified because industry must be accountable for the worker's welfare and for efficient production which go hand in hand. Improvement in a worker's health means greater efficiency and less turnover of labor. Moreover, such contributions are justified because this is a social measure.

From the standpoint of the employee, he is already paying considerably more without receiving corresponding benefits.- This point is debatable.- The state, on the other hand, is already defraying much cost of sickness in general, and so, government contributions to health insurance are" not only natural, but may represent a saving on present outlays for crime and indigency."[2]

The expenditure of these funds would be through representative councils in each locality with "powers to make agreements for the remuneration of the health profession, according to the method preferred by the physicians themselves."[3] The idea being that of panel service. All physicians and hospitals in the state wishing to join would be eligible, and remuneration would be on a

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1. Rorty, James H. American Medicine Mobilizes. New York: W.W. Norton & Company, 1939, p.295.

2. Ibid. p.296.
3. Ibid. p.295.

"unit schedule" basis.

This represents a maximum program compared with that already tried in other countries, but we like to do things in a large way. As to the success of compulsory insurance programs in other countries, there seems much to be said for and against them. Much yet remains to be done in this line.

The question arises as to the reaction of the wage-earner to one more attachment on his pay envelope. What of the employer's attitude ? He may already be providing a better and more adequate medical care. What as to any control over the type of care which the individual receives, since he may choose any eligible doctor ? What of the service rendered by physicians who know they will receive only a low and proportionate fee ? Still more-what of political control, so detrimental a factor in much of our social legislation today ?

We need provisions for health insurance in some form for the people in the group below $3,000, no doubt, but non-political control would seem to be a more democratic right, with freedom of choice in the matter of insurance. Why not require us to spend a certain amount for food, for proper housing, and have the employer add that to his expenses ? We might attain the same ends, but would we feel that such a measure was justified ?

For those on relief or on the subsistence level, have tax-supported health centers, hospitals and clinics, or non-profit organizations reimbursed by the state; but for those above that level, let us still preserve the right to freedom as long as possible.

(2) Community Medical Centers.

Dr. Atkinson, in Behind the Mask of Medicine , describes the future of medical practice as based on team play, or the team. Future medical care built around the hospital as the center of the unit, this unit supported by private, philanthropic, state and federal funds as necessary. The large hospitals would serve as the hub of the wheel and contain the offices of the staff. All consultant work would be centralized at this point. The rim of the wheel would surround all areas served by the hospital. Nearing the ends of the spokes would be the out-patient clinic and small hospitals from outlying districts where the teams of practitioners would each have their offices and take care of all work not needing to be sent to the central institution. In order to serve the population as a whole, hospitals and clinics will have to be established part way along the spokes of the wheel. All practitioners in the areas would automatically be members of the staff of the central institution as well as of the neighbor hospitals and clinics. Those physicians serving on the periphery of the wheel would constitute the out-patient staff, while those on the central staff would form the inpatient staff.

Thus, all our medical needs would be taken care of through group, not private practice. Every physician would be part of a hospital system, not struggling for an appointment on one. All would receive pay through a central office organization, and patients would have access to all advances in medical science.

(3) Community Health Centers.

This is a proposal for meeting not only medical service needs, but for covering health service as well, health education, and recreational facilities.

Dr. Paul de Kruif, in Toward a Healthy America, pictures for us the future in the following way. He says that the real strongholds in that battle area of the fight for life must be in the laboratory health centers. Each of these health centers will house a modern laboratory which would be manned by trained laboratory workers, pathologists, chemists, and X-Ray men. Here, also, will be housed not only X-Ray apparatus, iron lungs,blood-grouping and blood transfusion machinery, oxygen tents,electrocardiographs, metabolism machines, some stationary, and others which can be carried to farm homes. Medical and health consultants will also be there to co-work with the family physician. In addition, there will be libraries through which the physician may keep abreast of modern medical science. Finally, "these health centers must be life-saving lighthouses for the people, must be rallying points, meeting places for parents, young people, children. Here by lectures, movies, our doctors can tell us the stirring stories of how science can build our strength. And just as doctors will be health teachers of the people, so the people can teach their own needs to health men and doctors."[4]

How does Dr. de Kruif plan to finance these health centers? Through funds shared by local, state, and federal governments.

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4. de Kruif, Paul. Toward A Healthy America. New York City:Public Affairs Pamphlets, No. 31, 1939, p.26.

Such a powerful program of health conservation will, he feels, save incalculable sums now spent and those to be spent in the future for keeping half-alive millions of citizens who are not so sound or the resourceful, energetic human beings that they could be- a chief cause of social insecurity today.

By using the science available today, "the money-saving effected by keeping our citizens from spending lives as unproductive, tragic, sub-human vegetables in asylums, would begin within a couple of years. The accumulated saving of dollars now frittered away to maintain the madness, blindness, heart-break, the pitiful deterioration of syphilis, would within five years begin to be a good-sized credit in out national bookkeeping."[5]

Thus speak the proposals for future organization of medical care. Time alone will prove the outcome.

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5. Ibid. p.29.

CHAPTER VIII

A GLIMPSE INTO THE FUTURE

Dare we predict what the future may hold ? Dare we even attempt a glance into the crystal bowl ? But let us surreptitiously take a brief peek, and see some of the possibilities which it holds.

Certain facts have been shown us. There are great numbers of people receiving little or no medical care. We know that 80 per cent of the population, between the indigent and the well-to-do have a problem in budgeting for unpredictable expenses of sickness. Life expectancy has been raised from 40 years to 65 years of age; infant mortality has been greatly reduced but it still is high wherever economic status is low; one-half to two-thirds of maternal deaths are preventable and could be decreased if the majority of mothers in low-income families received adequate pre-natal care; the death-rate of infants in the first year of life can be cut in half;mortality from tuberculosis, cancer, pneumonia, syphilis, and other chronic diseases has been greatly reduced, but the waste through incapacity is still great.

One out of 22 people in the United States is unable to work, attend school, or carry on their usual activities during the winter months because of illness, injury or impairment, and 57 per cent more illness disabling for a week or more occurs among families on relief than among families in the $3,000 income group.

We know also "that 40 million people live on annual family incomes of $800 or less, which permits them an emergency standard of living and makes it impossible for them to purchase medical care--- that there is another third of the population whose family income does not exceed $1,500 a year." [1]

For this third, budgeting for medical care is very difficult even though they are willing to pay, at least, in part, for the medical care they receive. There is still another group made up of millions whose income is more than $1,500 a year but who find that medical care and saving for its unpredictable cost are serious problems.

We know that together with this whole problem of medical care and sickness go low wages, poor housing, and sanitation,poor nutrition, unemployment, inadequate recreational facilities and opportunities, poverty, crime, degeneracy, and dependency.

What, then, does the crystal bowl show us as to public organization of medical care for the future ?

1. Hospital and clinic facilities including birth-control clinics, will be increased and extended to include the rural and scattered districts either through small hospitals or mobile hospital units. The expenses will be met partly by individuals and partly by subsidies by the state and through federal grants-in-aid, or by taxation. Staff members will receive salaries according to experience and responsibility.

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1. Sigerist, Henry E. A Health Program for the American Pepple. New York: People's National Health Committee. Reprint from Atlantic Monthly, June, 1939. Vol.163, No.6, p.1.

2. Extension of all means of prevention, and of care of chronic illness. This will come principally through local, state and federal governments, because of the extreme cost which the average individual is unable to bear.

3. Increase in private, non-profit, fee-for-service clinics.

4. Increase in group prepayment plans for medical care of all types, with the inclusion of the lower income levels. Special emphasis will be put upon those under the auspices of state medical societies. The extent of sickness, hospitals, and nursing coverage will vary, and where wisely carried out, will develop according to sound economic plan. This will enable the vast middle-class group to protect themselves and society.

5. Development of group prepayment plans to cover the low income group with the expense shared by employee and employer; and increased plans in which the entire cost is carried by industrial and business concerns as a part of the overhead expenses.

6. The development of compulsory health insurance for the low-income group, with contributions from employees, employers, and the state. Some plan must be evolved to help cover people of low middle-class earning power, if national health is to be kept at a high level.

7. Specialists will tend to lower their exorbitant fees in line with social conditions, in general. No longer will the rich or the middle class be asked to carry more than their share.

8. Individual practice will still be an important part in the picture for some time to come, for society is slow to change.

Many people prefer this system, and find it very satisfactory. Moreover, the general practitioner will still do business, both on his own, and in relation to group and panel plans.

9. The public health functions of housing, sanitation, food protection, and recreational facilities will be improved from time to time by the state.

10. Education for preventive care, and positive health, will be carried on, not only through private agencies, but through the public schools, where the provisions now made will be increased in many instances, and through state agencies.

Thus, through many different ways, our national problem of medical care will be met. Our rural population and our low income group will be taken care of. Our infant mortality rate will be still further decreased, and our maternity outlook will improve. Incapacity, as well as death,from chronic disease will be lessened, and many of the people so afflicted will be at least partially self-supporting instead of dependent. Our life span not only will have been lengthened by medical science, but the incapacities of middle age and of old age will have been reduced. In turn, increased employment will mean increased income (we hope), more social security, better living standards and conditions, and greater productivity, health and happiness for all.

Time and changing conditions alone will shape the pattern of this picture; but social progress demands the harmonious solution of this problem, even though that solution fluctuate and vary from time to time. Progress involves a certain degree of change, though change of itself is not necessarily progress. Civilization will continue to progress,and medical science and care will be in the procession- just where,how, and when,time will tell.

ABSTRACT OF THESIS

"The health of every individual is a social concern and responsibility." In times of depression, the health of society decreases, moral standards tend to become lower, living standards drop, and society tends to retrogress.

The health problem presents three definite aspects: 1) positive health; 2) prevention of disease; 3) treatment of disease. Positive health is little appreciated by society as a whole, and no special program has been envisaged. Preventive health has made great strides of advancement, and has become a matter largely of public concern, control, and financing. Treatment of disease has always been considered the responsibility of the individual, but changes in population distribution, in industrialism, and in the advance of medical science, are fast trying to force individual medical practice into the background.

Approach for the Paper

Books, reports, reprints, magazine and newspaper articles, and personal interviews with professional and non-professional people have provided the materials used.

Adequate Medical Care

Good medical care is a varying quantity, and depends on the needs of the individual. "Adequate medical care" consists of whatever the trained judgment of a recognized diagnostician and physician perceives to be necessary for returning the individual to health and to competency."[2]

1. Rorty, James H. American Medicine Mobilizes. New York: W.W. Norton Co.,1939, p.228.
2. American Foundation. American Medicine Expert Testimony Out of Court, Volume 1, 1937, p.2.

Cost of Medical Care

The cost of medical care depends on the extent and the quality of service rendered. The hazards and unpredictability of sickness make it practically impossible for the average person to budget and to save against lengthy sickness and unexpected accidents. The incidence of sickness and accident is greatest for the low income level. The amount of care received varies also with the income level.

The average individual spends from 4 to 5 per cent of his income for medical care. The government spends approximately five hundred twenty million dollars annually on public medical service. In spite of all this, the average person lacks medical care of all types, and the hospital, dentists and physicians have many financial problems.

Innovations in Response to the Situation.

Non-prepayment and prepayment plans have been developed to meet the situation. The free or low cost clinic and out-patient departments take care of the charity, low income, and often other group levels. The fee-for-service clinic fills a great need of the low income, middle and upper income levels.

The prepayment group plans evolved include: voluntary insurance under commercial insurance companies and non-profit programs of group medical practice. Under the latter we find:

a. industrial plans; b. plans by medical societies and other groups of physicians, including group hospital plans; c.

provision of physicians' services by a non-profit organization; d. consumer cooperative plans; e. aid under the Farm Security Administration; f. college and university groups; g. salaried town physician.

Advantages and Disadvantages of Group Medical Care.

The proponents of group medical care claim the following objectives for their plans: increased professional efficiency; satisfaction to patients; realization of economy; and proper compensation for physicians.

Objections to group practice have been raised largely by the American Medical Association. It contends that these objectives are not realized and that the following objections exist: medical care becomes a commodity, not an individual service; the intimate patient-physician relationship is lost; free choice of physician is eliminated; the cost of medical care is not reduced; unfair competition is presented, because the individual physician may not advertise and the group can advertise; professional standards are lowered; cheap service results; the physician does not receive adequate compensation.

Conclusions Reached from Study of Various Plans.

The clinics and out-patient departments are meeting a need of the charity patient, but are often abused by the patient who can pay. The staff receives no pay or is poorly paid, and thus carries a large share of charity.

The fee-for-service clinic is playing an increasingly important part in adequate care for the middle income groups, as well as for the well-to-do. It also offers help to the low income group. Its service is excellent. Its physicians are adequately recompensed. This is not the type of group practice to which objection is registered.

Other plans of group practice vary in: the completeness of service; in the initial and total costs to the subscriber; and in compensation to the physician or hospital. Vital factors in all these plans are: slow growth; vast number of subscribers; wide spread of medical hazard; and control of standards by the medical profession. This last is especially true in the case of consumer cooperative plans.

Indications are that these plans are more or less successfully meeting the needs of employed groups and their families of average income levels, but need to be extended to meet the needs of the lower income group.

Local, State and Federal Provisions.

During the past twenty years, local communities and states have done much in the lowering of mortality and of morbidity rates. Maternity and child health care have been important. Care and rehabilitation of the chronically ill have lessened unemployment and dependency. Prevention of disease and improvement in sanitary conditions have all helped to reduce the average man's health problem, and to make him a more productive meber of a community.

The degree to which local communities and states have developed their programs has depended on the interest of the people, the funds available, the state and federal laws, and the governmental grants-in-aid.

The federal government has assumed responsibility for the medical care of certain non-dependent groups. It has been of paramount importance in all preventive measures of health. Through its grants-in-aid for maternity and child health programs, it has aided in reducing infant mortality and maternity risk. Through its wide program of grants-in-aid, under the Social Security Act, and other legislation, it has provided extension of medical care in practically every field.

The conferences it has called, and their recommendations for the betterment of health and medical care have caused commendation on the one hand, and fear and protestation on the other. The issue of compulsory insurance, the extension of government control, and the furtherance of tax-supported medical care remains a hotly debated question.

Proposed Plans

Among the suggestions for improving medical care are: 1) compulsory insurance for at least all groups with the given income level of $3,000 or under; 2) community medical centers supported by private, local, state and federal funds; 3) community health centers supported by private, local, state and federal funds.

Thus, provision for positive health, prevention and treatment of disease would be available to all from the farmer to the city dweller.

A Glimpse Into The Future

Means must be and will be devised to meet the needs of our nation for adequate medical care. The mortality and morbidity rates must continue to decrease; communicable disease prevention and control must increase; control of chronic illness must be extended; non-employment,dependency, low standards of living, poverty, crime, and degeneracy must all be lessened and eliminated in so far as possible. Ways of doing this will be:

1. increasing and extending hospital and clinic facilities through individual, state and federal funds.

2. increasing and extending all means of preventive health, largely through state and government appropriations.

3. increasing the number of fee-for-service clinics.

4. increasing all forms of group prepayment forms of service, with service extended to the low income group.

5. lowering specialist rates.

6. adding part-time salary or panel service reimbursement to his regular fees by the individual practitioner.

7. making possible compulsory health insurance for the low income group.

8. increasing educational and positive health programs through private, state and federal control.

The pattern will evolve and change as time goes on. Social progress demands the harmonious solution of the problem, and time alone will show exactly how the pieces of the puzzle will fall into place.

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